S. HRG. 101-901

PROPOSALS TO EVALUATE THE FUTURE STRUCTURE OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH–CARE SYSTEM

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

S. 1332 and S. 1398

MARCH 28 AND APRIL 4, 1990

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PROPOSALS TO EVALUATE THE FUTURE STRUCTURE OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE SYSTEM

WEDNESDAY, MARCH 28, 1990

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:40 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (Chairman of the Committee) presiding.

Present: Senators Cranston, DeConcini, Murkowski, Thurmond, Specter, and Jeffords.

Senator DECONCINI. The Veterans' Committee will come to order. The Chairman is on his way and has asked me to open the meeting.

Mr. Secretary, we are glad you are here, and those who are with you. Before we hear from you and have you introduce the panel, we will yield to the Ranking Member, Senator Murkowski. Happy birthday, Senator.

Senator MURKOWSKI. Thank you very much. That's very thoughtful of you.

Senator DECONCINI. I will yield to the Senator from Alaska for any opening statement.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. I thank my colleague from Arizona and I appreciate his birthday wishes.

I have a short statement which I will take this opportunity to read.

The opportunity to join with my colleague from California is one I always welcome and as he will be here in a few minutes, I just want to say that I join him in extending our welcome to our witnesses today.

I am especially pleased that the Secretary and his Deputy are with us. Neither need introduction to this Committee but I think the title of their Commission, which is the "Mission Commission," is rather catchy and hopefully there won't be too many caught in any trap that is laid, suggesting the ultimate motives of this Commission. I happen to think this effort is long overdue.

I have known the Secretary and Mr. Principi over the years. I know that they have been criticized, to some extent, for their initial efforts which suggest that we take a look at VA benefits and services, including this Mission Commission. I think that the criti-

cisms are questionable in the sense that the examination is pretty hard to criticize in general terms.

I think it's fair to say if any department or agency of Government, including the Department of Veterans Affairs, is unable or unwilling to make an honest assessment of its programs, then I think we have a problem in Government. The reality is that those programs which are effective and meritorious are, of course, going to remain unchanged. They are not threatened by any means.

However, I fail to understand why anyone would so strongly oppose any objective or open-minded look unless there is a feeling that the current programs or benefits for some reason can't stand the eye of public scrutiny.

Last summer I introduced S. 1332, which would have required the Secretary to establish an independent commission, modeled after the Department of Defense base realignment concept, to examine the mission of the VA medical facilities, to determine if mission changes, realignments or closures were needed.

I was surprised to learn that a study of this magnitude has not been done in over 25 years. I don't know that there is any other agency in Government that hasn't had a self-examination in a reasonable period of time.

Certainly significant changes have occurred over that time. Veterans' needs have changed, our veteran population has aged—some have moved to the Sun Belt—medical technology now permits services to be provided, in many cases, without hospitalization, and we know the needs have increased for long-term care such as domiciliary care. Simply put, the configuration of VA's medical care system in the minds of most who are in the health-care system would suggest that VA has not changed with the times.

The legislation which I proposed does not envision, require, or imply a reduction in VA services. My goal is to shift resources and allocate services to areas, locations, and types that can be more effectively and efficiently used. It was my conviction all along that the needs of veterans change and that the programs should change correspondingly.

Let me further note that S. 1332 permits the Commission to recommend closure of VA facilities, and I know that gets a reaction from many of the service organizations, but what I would like to point out is it does not require that such closures be recommended. I believe it is unwise to preclude or restrict the Commission from looking at options, including closures, if it is shown that such an action improves services to veterans on the whole. I think it is simply a matter of continually reviewing the priorities of veterans and reprioritizing those where it is appropriate.

I was pleased that the Secretary also sent to the Congress a bill to provide for an independent hospital mission commission. I think his efforts are noteworthy.

I remain convinced that the legislative approach, particularly as it relates to congressional consideration of the Commission's recommendations, perhaps is the best way to go. That is in lieu of a strong administrative capability which I think rests in the Secretary of Veterans Affairs at this time and under the leadership of the gentlemen that we have before us, Secretary Derwinski and Mr. Principi.

I recognize the opposition to that approach. I understand it has been expressed by our counterparts in the House. I understand the House much prefers the administrative approach and I believe that is what we are going to hear from the witnesses today. I think it is healthy to have an active dialogue and I think that's what we are going to hear.

Again, I would caution those who feel that somehow this is an attack or an undermining of the VA health-care system, this is simply good Government in action and I would encourage those that see this as an effort to somehow tear down the VA services, that indeed is not the intention of this Senator. I think that this represents a majority of our colleagues who would say we should look at Government services on a timely and regular basis. These efforts are needed during these changing times and conditions.

Mr. Chairman, I note you are with us and I believe you have a statement as well. Good morning.

Chairman CRANSTON. Thank you and happy birthday to you.

Senator MURKOWSKI. Thank you once again.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. Dennis, thanks for opening the hearing.

Good morning to everyone. I welcome you to this hearing. Today the Committee will consider various proposals—two legislative, one administrative—for review and restructuring the VA health-care system.

The two bills on today's agenda are S. 1398, an Administration bill, and S. 1332, a similar bill by Senator Murkowski, to establish a commission to make recommendations for realignment and possible major mission changes in VA medical facilities. The chief difference between the two measures is that Senator Murkowski's bill would allow VA facilities to be closed whereas the Administration bill expressly would preclude any closures.

Both measures are designed to require Congress to vote up or down on the recommendations emerging from the Commission. The administrative proposal on the agenda is the Commission on the Future Structure of Veterans Health Care, which Secretary Derwinski has announced he will establish without legislation.

When the Administration submitted its legislative proposal, S. 1398, I said I would work with the Secretary to try to develop acceptable legislation. However, Chairman Montgomery has declared his unswerving opposition to the statutory commission with recommendations having to be accepted by Congress on an all-or-nothing basis. Without such a mechanism, there is a real risk that the Secretary's Commission, however well intended, will expend much time, money and effort only to have its recommendations rejected 1 by 1 by the Congress.

I am very interested in learning more about the Secretary's plans for the Commission, including details about the proposed amount and source of financing, how the members will be selected and who they will be, when the Ccommission will begin work, and his timetable, how often it will meet, and whether and when its members will visit specific sites, how it will go about evaluating the vast VA system, and how the Secretary hopes to insure its in-

dependent nature and therefore its credibility. That credibility will be extremely important to the ultimate outcome of the Commission's recommendations.

I believe it is important that the Commission understand a number of things as it begins its work. First, the Commission must understand in depth the characteristics and needs of the various categories of veterans who rely upon, and in the foreseeable future can be expected to rely upon, VA for health-care services.

The Commission should keep in mind VA's role as part of our national health-care system, much as I urged Senator Rockefeller to do as Chairman of the Pepper Commission.

The Secretary's Commission should understand VA's vital role in the education and training of this country's health-care professionals as well as the furthering of scientific knowledge through its research programs.

Finally, the Commission should remember VA's statutory commitment to back up the Department of Defense health-care system in time of war and VA's role in natural disasters, as shown most recently by the health care and counseling that VA facilities and staff provided so well in the aftermath of the catastrophic Loma Prieta earthquake in the Bay Area of San Francisco.

I want to address what I understand as of now to be the Secretary's plans for funding the Commission. As I understand it, VA is now proposing to fund the Commission this year in part by asking Congress to approve by legislative transfer into the medical administrative account—called MAMOE—of a certain amount of this year's medical care account appropriation and next year to switch into MAMOE a certain amount of requested medical care funding.

Other support would come in the form of detailing to the Commission VA personnel who are already paid under the MAMOE account or the general operating expense account and for whom reimbursement would not be provided to these accounts.

Fifty-one Senators and I feel strongly that VA medical care is drastically short-funded this year. I cannot support any proposal that in order to set up this administrative study commission, we divert funds from their intended purpose of supporting the provision of care or benefits to veterans. If the Administration insists on an offset, it should find one that won't take funding away from veterans dependent on VA for their health care.

What I would propose as an alternative is that the fiscal year 1990 and fiscal year 1991 funding be provided through an appropriations bill provision authorizing VA to retain and use for the expenses of the Commission up to a specified amount of the funds it collects as third-party health insurance reimbursements which would otherwise be transferred to the Treasury. That approach would avoid the need to divert funds from the medical care, MAMOE, and GOE accounts for the costs of the Commission.

In my opinion, none of these three accounts has extra funds to spare from their intended uses—the furnishing and Administration of VA health-care benefits.

This morning, we will hear from a number of witnesses who are highly qualified to comment on the mission of the VA's health care system and the best way to go about evaluating it. First, we will hear from Secretary of Veterans Affairs Edward J. Derwinski and

other VA officials. Next, representatives of various veterans service organizations will share their concerns and suggestions. The next two panels have unique perspectives on VA health care as well as a great degree of firsthand knowledge.

I look forward to hearing their views on the various legislative and administrative plans to evaluate and restructure VA's health-care system.

I now will recognize Senator DeConcini.

OPENING STATEMENT OF SENATOR DeCONCINI

Senator DECONCINI. Mr. Chairman, thank you very much and I apologize to the Secretary. I have to go to another hearing before the Appropriations Subcommittee of Treasury, IRS and Postal Service which I Chair.

I want to thank you, Mr. Chairman, for the prompt scheduling of the hearings regarding the most important issue of concern to the veterans in my home State of Arizona, and that is comprehensive realignment of veterans' medical facilities. It took a lot of courage for Secretary Derwinski to even raise this issue and I commend him for his steadfast approach to this matter despite the heavy criticism that I know he has come under.

I strongly agree that it is high time after almost 25 years for a comprehensive review of the quality and effectiveness of the VA medical care system. The criticism made so far, however, should have been expected. We have been through these problems before. Veterans are afraid that this is the beginning of the dismantling of the VA health system. Based on some history of very poor budgeting and requests for appropriation through the last 8 years, particularly under the Reagan Administration, I can understand why this fear would be raised when the Administration is now suggesting that we take a look at facility realignments.

However, to offset that, I think the Secretary deserves great credit for his leadership on last year's supplemental appropriations bill. The President also deserves credit for support Ed Derwinski's request. Ed's willingness to take it all the way to the Oval Office when he believes that his Department is not getting a fair shake from OMB or anybody else is certainly a breath of fresh air. I think his willingness itself is enough to dispel concern that the Secretary is in any process toward dismantling. I am convinced he is properly addressing all veterans' needs in this realignment review.

Mr. Chairman, I want to thank Mr. Principi for coming out to Arizona for the dedication of the new center in Prescott, and I will submit the balance of my statement. Thank you.

[The prepared statement of Senator DeConcini appears on p. 118.]

Chairman CRANSTON. Thank you very much, Dennis.

Senator Thurmond, do you have any opening remarks?

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Yes. Thank you, Mr. Chairman.

Mr. Chairman, I am pleased to be here this morning to consider realignment and major mission change legislation for medical facilities of the Department of Veterans Affairs. The proposals put

forth by the Department, S. 1398, and by the Ranking Member, Senator Murkowski, S. 1332, deserve our careful attention.

Mr. Chairman, as we know, there has not been a comprehensive review of the distribution of health-care resources to veterans in the last 25 years. Since the establishment of many Veterans Affairs facilities in the post-World War II years, there has been a significant shift in the population of veterans in this country. Many older veterans have moved south, a good direction to move, I might add. In addition, there have been increases in the number of elderly veterans, major advances in medicine and the emergency of more ambulatory care, extended care and community-based outreach care.

Mr. Chairman, with all these changes and advances, it is time for us to conduct a review to help insure that we have the most optimal and efficient distribution of health-care resources. I am pleased with Secretary Derwinski's initiative in this matter and praise him highly for it. I think Secretary Derwinski is doing an outstanding job as Secretary of the Veterans Affairs Department and we are proud to have him there in that position.

It is only through a comprehensive evaluation of resources such as is before the Committee today that we can determine the best distribution of these resources for our veterans.

Thank you, Mr. Chairman. Shortly I will have to leave for another meeting, but I am very pleased to support Secretary Derwinski and support the movement to accomplish the goals outlined in this legislation.

Chairman CRANSTON. Thank you very much, Strom.

The first panel we will now proceed with is made up of Secretary Derwinski, who is accompanied by Deputy Secretary Tony Principi; General Counsel Raoul Carroll; Chief Medical Director John Gronvall; and Marjorie Quandt, the Executive Director of the Secretary's Commission on the Future Structure of VA Health Care.

I am delighted to welcome you all here this morning and look forward to exploring the issue of the Commission in some detail with you. I want to say to John Gronvall, this may well be your last appearance before this Committee as Chief Medical Director after many appearances in that capacity, and I want you to know that we have always greatly valued your input, your testimony, your wise counsel, and your forthrightness. We wish you only the very best in your future endeavors, which I know will be as distinguished as have been your many accomplishments.

Mr. GRONVALL. Thank you very much, Mr. Chairman.

Chairman CRANSTON. Thank you. Ed, would you now proceed?

STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY HON. ANTHONY J. PRINCIPI, DEPUTY SECRETARY; DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR; MARJORIE R. QUANDT, EXECUTIVE DIRECTOR, COMMISSION ON THE FUTURE STRUCTURE OF VA HEALTH CARE; RAOUL L. CARROLL, GENERAL COUNSEL

Secretary DERWINSKI. Mr. Chairman, I have a detailed statement I'd ask be placed in the record in full.

Chairman CRANSTON. Yes, it will.

Secretary DERWINSKI. Befitting my training in the House, I will be relatively brief in summing up the statement.

In the year I have been Secretary, I have had an opportunity to visit many of our facilities across the country and many of them indeed are impressive. I have also been able to meet with the personnel who run those facilities, and again, we have tremendous talent and leadership in the VA. But we are also facing problems. The budget problems are the obvious ones.

The rising costs of medical care affects us. Although right at the moment we are basking in the pleasure of a very impressive 1991 budget figure, we think. Nevertheless, we have to acknowledge that we can't go beyond just simple budget figures and we have to emphasize management initiatives and a comprehensive review of the VA. That is what we are asking for and that is what we presume to be able to work out.

I believe you are accurate, Mr. Chairman, when you state the situation in the House. I don't believe we can get legislation there, so we are focusing now on the steps we are going to take administratively to have this Commission operate.

There are changing needs and more specialization developing in medical care. There are rising costs of delivering medical care. We are faced with the challenge of replacing outdated equipment, renovating outdated facilities, staying current with modern medical trends and all of those challenges we face.

In addition to that, we have a very major circumstance which we acknowledge and that is the aging of our veterans. Our figures show that by the year 2010, 60 percent of our veterans will be over 65 years of age; 35 percent of our patients will be over 75 years of age. Of necessity, we have to address that reality.

You probably know that we haven't had a thorough review of our medical care system in over 25 years. I think any objective person would realize that the review is long overdue.

The Commission will be asked to focus on the years from 2000 to 2010, the primary goal being to assure the best care possible on an equitable, nationwide basis to all of our veterans. We hope to have members on the Commission from all fields of medical care—health science, health policy, health education, health research as well as veterans advocates.

It's going to be, in my judgment, to the extent that we can influence it, a totally independent Commission. We are not going to give the Commission a prejudged goal to reach. We want the Commission and expect all of the members to be working members. We are not going to have any facade kind of appointments. And we will take their recommendations based on what we believe will be collective wisdom, common sense and the genuine interest in where the VA should be 20 years from now and how it should be effectively serving our veterans.

The interest and concern of congressional oversight committees is something we are very sensitive to. We understand the special concerns of the VSO's. We pledge to communicate with this Committee, other committees and with the VSO's, and with all interested non-VA parties. The deliberations of the Commission will be open and their field missions will be open. They will be conducting

hearings in the field. When this is over, we want this to be an extensive, effective and therefore, acceptable series of recommendations as we can possibly have.

The only goal is to help us reestablish—not so much reestablish but fine tune, a VA that more effectively serves our veterans in the year 2010 than we might possibly be able to do if we just tried to work within the status quo and move from year-to-year and crisis-to-crisis.

It is in that general sense, Mr. Chairman, that we appear before you. I am pleased to tell you we have the total support of the VA community and the concept of this Commission. We appreciate the objective attitude of your Committee, sir.

Thank you.

[The prepared statement of Secretary Derwinski appears on p. 120.]

Chairman CRANSTON. Thank you very, very much.

Senator Jeffords, do you have any opening remarks?

Senator JEFFORDS. Thank you, Mr. Chairman. I will be very brief and just ask unanimous consent that my statement be made a part of the record.

Chairman CRANSTON. It will.

Senator JEFFORDS. It is certainly good to see you again, Mr. Secretary. Please proceed, Mr. Chairman.

[The prepared statement of Senator Jeffords appears on p. 119.]

Chairman CRANSTON. I will start off now with some questions. I recognize your stated desire, Ed, that the Commission be intellectually, technically and professionally free and your intent for it not to be overly proscriptive in your charge to the members of the Commission.

However, it seems clear that the assumptions that the Commission has on certain key issues will have a very significant influence on its findings. In that regard, I'd like to know what guidance you will give to the Commission members with respect to taking into account the following five factors.

First, what guidance will you give on categories of veterans entitled to or eligible for various types and levels of care and what guidance will you give on what assumptions about entitlement and eligibility the Commission should use to base its year 2000 projections upon?

Secretary DERWINSKI. They would be advised, Mr. Chairman, of the current law. We are making no recommendations to them or we wouldn't prejudge or want them to prejudge any changes in current law. So I think the realities would dictate that in their deliberations any questions of eligibility and entitlement would be based on current law and current policy.

Chairman CRANSTON. What about the matter of guidance and what assumptions about entitlement and eligibility the Commission should use to base its year 2000 projections?

Secretary DERWINSKI. I don't believe it would be practical, and actually I can't think of why we would ask them to make any assumptions other than the realities they're dealing with. I think the real assumption that we'd ask them to face is the one we all know is there, the aging of our veterans. The other assumptions are that there will be continued progress but also corresponding expense in

the delivery of medical care and that the VA must stay abreast of all the technological and scientific breakthroughs in medicine.

Mr. PRINCIPI. I'd just like to add that as you well know, we are considering eligibility reform in a broad area of veterans benefits and health-care services with a view to expanding entitlements in health care for category A veterans from preventive care all the way to hospice care. So we are looking at a broader continuum of care and we are looking at expanding category A eligibility. If we are successful in getting those proposals through the Administration and favorably considered by the Congress, certainly the Commission would take them into consideration at that point in time.

Chairman CRANSTON. Will you ask the Commission to consider the need for changes in current law and regulations regarding entitlement eligibility and priority for care?

Secretary DERWINSKI. We feel they are going to have a full plate just evaluating our resources, our structure, the location of some of the facilities, the mix of specialties and all those tremendous challenges in medical care delivery.

Chairman CRANSTON. What guidance will you give about assumptions regarding the role and importance of VA's affiliations with health-care training institutions, both to VA and to the affiliated institutions and, therefore, to the whole Nation?

Secretary DERWINSKI. Our affiliation and relationship with medical schools, we think, is one of the great assets of the VA. Certainly the type of medical leadership we will have on this Commission, I would assume, would be most understanding, appreciative and positive toward our tie-in to medical education and would certainly want it continued. In fact, I see nothing in our Commission that would be anything but positive in the sense of that overall relationship to the medical schools across the country.

Chairman CRANSTON. Will the Commission be charged with assessing the impact on a teaching affiliation of each particular recommendation it's considering?

Secretary DERWINSKI. I honestly don't believe, Mr. Chairman, that they will get to that fine detail. That relationship is vested in the best judgment of the Chief Medical Director and those relationships go back, most of them, over 40 years. They have gone through the test of time and I cannot, using any possible stretch of the imagination, see any negative factors impacting on our overall relationship to medical schools. Most of our individual affiliations, I am advised, are in fine shape, but I would yield to Dr. Gronvall.

Chairman CRANSTON. Let me ask the question in a slightly different way. If the Commission recommended, for example, that surgery be dropped in some particular institution, would the Commission consider the impact on an affiliated institution in that location of dropping surgery in that institution?

Secretary DERWINSKI. Obviously they would and they would have to, but I would point out there that—and I often use this example—we have in Chicago three major VA medical centers, each exactly 6 miles apart from the other, each affiliated with a different medical school. If, in the judgment of the Commission, there should be some concentration of a specialty, I think the individual medical schools in their own, let's say, practical as well as philosophical support of the VA, would be willing to make some adjustments. I

use that just as a hypothetical case. But I think if there are such developments, they would tend to be in urban areas where transportation problems and access would not be a factor.

Chairman CRANSTON. I take it that would be part of the charge, to take those matters into account.

Third, what guidance will you give about assumptions regarding the role and importance of VA research, not only to the quality of care provided by VA and the VA's ability to recruit and retain top health-care professionals, but also as part of overall national research strategy and activity?

Secretary DERWINSKI. We see nothing in the makeup and general types of leadership on the commission that would be anything but most positive toward research.

In fact, aside from this Commission we are discussing, we recently appointed a special VA committee to help direct us toward more effective use of our research and I think we will give, and continue to give, fullest support to research as a key part of VA medicine.

Chairman CRANSTON. You would indicate that to the Commission?

Secretary DERWINSKI. Yes, definitely.

Chairman CRANSTON. Fourth, what guidance will you give about assumptions regarding VA's relationship with DOD, both in time of armed conflict and for the sharing of resources?

Secretary DERWINSKI. The policy that we have hammered out the last year is extremely positive, and I might even say almost aggressive, in seeking effective relations with the individual branches of the armed services and their medical components. I would say in a general way, Mr. Chairman, my assumption is that given the budgetary pressure that the DOD faces, sharing agreements and joint ventures will become increasingly attractive and practical for them. I think our position will continue to be very positive.

Chairman CRANSTON. Finally, fifth, what guidance will you give about assumptions regarding VA's role in any comprehensive national health-care effort?

Secretary DERWINSKI. We will be working with Secretary Sullivan and the other leaders in the public or private sector on any plans. We feel very strongly that the VA could well serve as a model for those who are looking at how to deliver effective national health care. That is why we would remind you, sir, we all often stress the fact that I attribute this to Deputy Secretary Principi, who is determined that all veterans in all parts of the country have equally good access to equally good medical care. That is our goal. We want an effective, national VA to serve all veterans wherever they may be.

Mr. PRINCIPI. We will have a representative from HHS and DOD serving on the staff of the Commission and we are certainly going to give the various commissions, the Pepper Commission's findings, the Social Security Commission on Medicare/Medicaid, any national health plans, the consideration that we would ask that they give to the VA. We don't believe they are giving due consideration to the VA in formulation of many of those plans but we certainly will take all of them into consideration. The Commission will take all of them into consideration.

Chairman CRANSTON. In testimony from the Association of American Medical Colleges, two suggestions about the Commission's mandate were made about which I'd like to solicit your comments.

The first was that, "The Commission can serve a useful purpose in reviewing exemplary affiliation arrangements and recommending ways other affiliations might be developed or improved to meet the health-care needs of an aging veteran population in the coming decades." Would that be part of your charge to the Commission?

Secretary DERWINSKI. We look upon that as a very constructive observation.

Chairman CRANSTON. Second, Dr. Korn stated, "I believe that the Secretary should be equally committed to accepting recommendations that might require increased resources to improve the system through realignment and enhancement." Ed, will you be equally open to such recommendations and will making such recommendations be within the Commission's scope?

Secretary DERWINSKI. I think the Commission will have to realistically look at our needs and our needs are going to include greater budgetary support over the years.

Chairman CRANSTON. You will indicate that specifically to them?

Secretary DERWINSKI. Yes. I am under no allusions that we could do better with less money. We are going to have to do better with better funding over the years.

Chairman CRANSTON. In describing guidance that the Commission will be given, your testimony refers on page 12 to "cost-effective care." What guidance will the Commission receive from you regarding the definition of cost effectiveness?

Secretary DERWINSKI. I don't intend, and I don't think anyone in the VA intends, to give the Commission precise directives and guidelines. We want the Commission to be aware of the cost of delivery of medical care. I think, again, if I may point out, Mr. Chairman, we intend to get the best qualified leadership and broad field of medicine and the sheer competence of that Commission, I believe, will be such that they won't need detailed directives from us.

Chairman CRANSTON. Thank you very much.

Frank, it's your turn.

Senator MURKOWSKI. Thank you, Mr. Chairman. I would yield to my colleague, Senator Thurmond who has two questions and is under a difficult time commitment for another meeting.

Senator THURMOND. Thank you very much, Senator Murkowski. I appreciate your courtesy.

Mr. Secretary, I just have two questions. What impact, if any, do you anticipate the results of the Commission might have upon medical construction projects that may presently be in the planning phase at the Department?

Secretary DERWINSKI. I don't feel there would be any major or certainly no negative impact, Senator, because one of the things the Commission of necessity will look at is the need for some of our facilities to be renovated, upgraded and in many cases, expanded. I would imagine from a construction standpoint, especially rehabilitation of some of our facilities, the Commission would be a positive catalyst.

Senator THURMOND. Mr. Secretary, what impact, if any, do you anticipate the results of the Commission might have upon VA research projects around the Nation?

Secretary DERWINSKI. I think keeping in mind the caliber of people we wish to have in the Commission, I believe they would be almost automatically as leading health professionals pro-research. I would expect them to strongly endorse and fortify our research programs.

Senator THURMOND. Mr. Secretary, I want to commend you for your leadership in this matter and I think it is very important to the whole Nation. Mr. Principi, we thank you too for your good service and the doctor, who is retiring, we appreciate all the good work you have done. The others who are here this morning, we commend you for your appearance.

Thank you, Senator Murkowski and Mr. Chairman.

Senator MURKOWSKI. With the Chairman's permission, I'd like to know something about your planning process. As you look into the next decade, 10, 15, 20 years, what is your lead time to plan a new hospital or substantially adjust for a change in outpatient capability, nursing care, domiciliary? Ideally, what kind of timeframe do you need, recognizing that you have to have the input from your people that are out in the field and review the recommendations and realities of the budgetary process and the committee process and the authorization?

Secretary DERWINSKI. I think the examples you cite, Senator, vary somewhat timewise but I will give you two current examples we are directly working with. We are about to improve a site in central Florida in the greater Orlando area for a new medical center. Once the site is selected, the environmental impact statements completed and everything that follows from it, it will be 1998 before the hospital doors are open and functioning.

On the other hand, after some early delay we approved the construction for an outpatient clinic in Savannah, GA and from the time of that approval, site selection, construction and completion the center will be functioning late this year or early 1991.

The time required to build domiciliaries would fall, I imagine, in between the two examples depending on the tie-in to an existing medical center. Keeping in mind everything from local zoning to staggered funding, to all the other factors, we're doing the best we can to expedite but time does run away from us on occasion.

Senator MURKOWSKI. Making an assumption that in 15 years, the year 2005, the number of World War II veterans in this country will be about 3.6 million, and recognizing, if you will, that currently there are about 9 million, I am curious to know what your plans are to address in 15 years a reduction of 65 percent of your World War II veterans that will not be there to avail themselves of the services that you offer?

Secretary DERWINSKI. If I may also read into your question the statistic that as we speak today, the average age of World War II veterans is 68, so those 3.6 million veterans you cite will have an average age of 83 in the year 2005. While the proportion isn't precise, the fact that the number of veterans will drop rather sharply is offset in our planning by the need to adjust to the fact that an older veteran will suffer from more and more ailments, the ail-

ments that come with age. So we will have perhaps fewer patients in the World War II veteran class, but they will continue to be a special challenge in the delivery of medical care.

Senator MURKOWSKI. I would assume that at some point in that projection the paths cross the other way?

Secretary DERWINSKI. Yes.

Senator MURKOWSKI. And the type of care that you are providing a World War II veteran now will change as his or her age advances. My question specifically is what kind of plans do you have underway now to meet the realization that in 15 years, you are going to be treating about 60 percent less World War II veterans and the veterans-type treatment will have obviously changed at that time?

Mr. PRINCIPI. The Commission will look out to the year 2010 and address the very issues that you're raising, Senator Murkowski, in planning for the future, the aging veteran population, the demographics of the veteran population. Clearly one of the key purposes and goals of this Commission is to address the very issues you are raising. There are so many unknowns at this time.

Secretary DERWINSKI. I might add you're looking to the Commission to give you input in the planning process.

Perhaps Dr. Gronvall could tell you precisely what we are doing at this time.

Dr. GRONVALL. Senator Murkowski, an additional way to look at that is to make projections about what we expect the demand to be in terms of kind and extent of medical care services needed by the total veteran population and project that out into the future. I think the demographic information that our planning people have is very good.

You are quite right that unless there are additional wars, which everyone hopes will not be, a peak of demand for care will be reached. Our best current judgment is that peak demand will occur between the year 2010 and 2015, following which it will stay approximately level for some time and then begin to decline. We have taken that into account in all of our planning in terms of horizons for hospital replacement projects, and nursing homes. The strategy we have had of increasing our reliance on community nursing homes, is in part, based on the desire not to be in the position that the VA overbuilds at any time for the predictable demand for nursing home care.

Senator MURKOWSKI. I am looking at a chart here that everyone that's interested in this subject should study because the realization of what the requirements on the VA in the area of health care from the standpoint of the aging veteran, moving on from World War II to Vietnam to post-Vietnam, is truly staggering from the standpoint of the accelerated reduction. I think it supports certainly the merits of this Commission.

The makeup of some of the restrictions on the Commission, of course, are what we are having to address here and we are following, I assume, the Department of Defense pattern pretty much in the realization that we went through a very difficult process in the legislative body to address the manner in which we would determine what bases were needed. I assume it's fair to say that in some

cases at least, the location of bases had something to do with the location of VA hospitals, at least in some of the rural areas.

I am concerned with the reality—and I speak for the indignation of some of the members of the public—that would suggest that the VA can't stand the scrutiny of changing needs and changing services. I think the public wants to see a realistic review, just as the public wants to see a continued commitment for the very best of veterans benefits, but to suggest that the system can't stand an examination, I think is an incorrect assessment be it by spokesmen for veterans organizations or some of my colleagues who see this somehow as a reduction in the health-care responsibility.

I don't think it is. I think it can increase the quality of the health-care responsibility and as I understand the legislation, if I am correct, the Administration's bill would not give you much authority to address the issue of closures if indeed they were justified, is that correct in the Administration's bill?

Secretary DERWINSKI. Yes. Frankly, Senator, that was the position that evolved in what we thought was a realistic appraisal of what we would face in Congress. In a perfect world, if all 535 members of the House and Senate were totally objective statesmen, we would not have had to worry. But the realistic world is such that we had to take into account the backlash from the base closing controversy.

Senator MURKOWSKI. I think it is quite evident that your assessment of the attitude and the responsibility of Members of Congress in ducking the issue, whether it be this issue or the base closures, was to contrive a system to address the problem that would give the necessary insulation from the constituency back home that somehow this wasn't something we dreamed up, it was a Commission responsibility. You folks have an obligation as administrators to make some tough decisions and make the recommendations to Congress, and we theoretically have an obligation to be responsive and hold you accountable. I recognize the system is not perfect and it doesn't always work that way.

Let me ask you this, in urban areas where you have several hospitals, as you've pointed out, Mr. Secretary, within 6 miles of one another, is it not conceivable that your interpretation to change services wouldn't be practical if you want to make one for nursing or domiciliary and just keep one for surgical? Is this within the realm of your interpretation of recommendations that are in the Administration's bill?

Secretary DERWINSKI. Yes, and that is what we would expect our Commission to look at honestly—the practical utilization of facilities to make more of our hospitals centers of excellence. Some of our medical leaders have impressed on me the term they use-centers of excellence,

Senator MURKOWSKI. Can you give us some suggested response to those who might say, this is an undermining of the system? In 30 words or less, how can you give our veterans' organizations and their spokesmen comfort that this is really an effort to try and increase the quality of veterans services as opposed to the generalization that many of our members will be subjected to that this is an undermining and the first major step, and it's going to follow what

happened to the bases, and as a consequence, reduce services to veterans?

Secretary DERWINSKI. Senator, we feel that all spokesmen for all the veterans' organizations have the best interests of their members and all veterans at heart. We would only ask that they give us reciprocal judgment. Personally, I feel that my obligation as Secretary is to make decisions in the best interests of all the veterans all across the country.

I personally feel that any challenge from any individual veteran group, especially those which impugn our integrity and our intention, is totally uncalled for.

Senator MURKOWSKI. I see my time is up and my colleague, Senator Jeffords, I am sure has some questions. I'd like to commend you for pioneering in this area. It's long overdue. I assure you that you have the support of the Senator from Alaska in your efforts.

I think it is important though that we recognize that we are already trying to package this, if you will, in the wrappers of a bit of a subterfuge which I think is very unfortunate. We have a bill come down from the Administration which in order to be palatable to us and our constituents back home, we have to hide in the guise that you really can't close anything even if it's needed. That is a sad state of affairs. Our obligation is to provide the services to veterans in the manner in which we can't stand up front and say we hold you responsible for providing the services, you make the recommendations, and we will agree or disagree, as the case my be, and that's the way you'd anticipate it would ordinarily be. But in this area we have found that we simply can't stand the heat, so we are saying OK, here is an Administration proposal that will address the issue, you'll get the recommendations but these recommendations can't include closures, even if they are needed.

That is why I think my bill is superior because it does give you that authority and after all, that's what responsible Government is all about, having responsible people making tough decisions and going with them.

Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

If the Senator from Alaska needs additional time, I'd be happy to yield to him. The questions that I had intended to ask have been asked by the other members. However, I would like to just talk a little bit about the rural areas and to insure that their needs are considered in this Commission report.

In Vermont, as you know, we have one veterans center which is in White River Junction which services the State of Vermont as well as six counties in New Hampshire, all rural areas. Over the years, because it is a very fine institution and is also adjacent to Dartmouth and the Dartmouth Medical School and Mary Hitchcock Hospital, a mutual dependency has grown up.

The very difficult time we have attracting doctors to rural areas is an extreme problem but the availability of an excellent hospital, excellent medical school, plus the research facilities at both the VA as well as at Mary Hitchcock have enabled us to attract a pretty sound, well-staffed medical staff. I would hope that would be kept

in consideration as to what the impact would be upon the whole region if there should be any change in that situation.

In addition to that, I suggest you take a look at how the communities and the center have worked together to cut costs. For instance, our regional community mental health centers now provide services to the veterans in that rather broad area to make it unnecessary for outpatient care at the hospital. The costs of those services are about half if they occur in the community mental health services as they would in outpatient hospital care. I am hopeful all that would be taken into consideration when they look into the rural areas where I think the needs are quite different from urban areas and where there is so much interdependency among medical institutions.

Otherwise, I thank you for your work and look forward to continuing to work with you.

Secretary DERWINSKI. Thank you, Senator.

Senator JEFFORDS. That is all, Mr. Chairman.

Chairman CRANSTON. With reference to the members of the Commission, when will they be selected and what effort has gone into their selection thus far, if any?

Secretary DERWINSKI. Our goal is to have them selected and functioning by early May. Ms. Quandt, could I yield to you to give the Senator the details of what you have been able to develop so far?

Ms. QUANDT. Mr. Chairman, approximately 50 medical and health organizations, along with eight veterans' service organizations, have been asked to send suggestions to the Secretary of potential Commission members. We are in the process of gathering those names, classifying them into the professional expertise, whether it's medical research, medical academia, multisystem management, in order to present those names to him.

The Chief Medical Director has also asked members of his staff to suggest names and we are awaiting those lists to come from within VHS&RA.

Members of Congress in committees related to veterans' affairs will also be asked for suggestions. It is anticipated we will submit all names to the Secretary and that hopefully we will have the decision for those 9 to 15 members by the end of April so that we may begin the Commission's work in May.

Chairman CRANSTON. Thank you. Who will make the final decision on the Commission membership?

Secretary DERWINSKI. Officially, I would but it would be after very, very detailed consultation with VHS&RA, with Ms. Quandt, with Mr. Principi and then with medical and veteran officials in the field as well as members of the appropriate congressional committees. We are going to have the broadest possible input.

Chairman CRANSTON. Before final decisions on membership are made, do you intend to get the input of the Chief Medical Director or Acting Chief Medical Director on the slate under final consideration?

Secretary DERWINSKI. Oh, yes. I make no pretext of being a medical practitioner myself. Even though I've picked up little pieces of medical lore, I am not ready to take any examination for medical practice yet.

Chairman CRANSTON. Will White House or OMB clearance be sought and needed for the appointment of Commission members or the appointment of Commission staff?

Secretary DERWINSKI. Frankly, no.

Chairman CRANSTON. I believe there needs to be consumer representation on the Commission. Will there be at least one such consumer, that is, a veterans representative?

Secretary DERWINSKI. Yes, Senator. If you translate consumer in our case to our key consumer, the veterans, we would hope to have someone who can be practically and properly identified as a veteran—not so much a spokesman for but someone very knowledgeable of the concerns of the veterans. But that will be a difficult post to fill. I will be looking for someone with medical knowledge as well as someone who also happens to understand all the veterans' perspectives.

Chairman CRANSTON. You would be looking for somebody with some expertise who also could serve and be recognized as a spokesman for veterans?

Secretary DERWINSKI. Yes. There are a number of people in the medical world who have had extremely close ties to the veterans' world and are respected as such.

Chairman CRANSTON. Obviously there are a lot of people in the veterans world who have had a lot of experience with the VA. Would you be interested in having veterans' organizations get together to try to present a joint list of proposed consumer representatives for you to consider?

Secretary DERWINSKI. I would be amazed if the veterans' organizations could get together and agree on a combined list. But if they perform that unlikely trick, we'd be most appreciative.

Chairman CRANSTON. I presume you'd give it some weight in your deliberations?

Secretary DERWINSKI. Yes.

Chairman CRANSTON. NFFE recommends in its testimony today that the Commission have representation from employee groups. What is your reaction on that recommendation?

Secretary DERWINSKI. You caught me a little off guard there. But in the sense that there is nothing in this Commission that would represent a challenge to the current employees of the VA. If anything we hope to have an expanded VA in the future, not a contracted VA. I think our employee groups will be best represented by the medical specialists on the Commission. We are going to have somebody who will be an expert in research, we hope to have someone representing the nursing profession, that kind of employee representation I think is logical.

Chairman CRANSTON. If the mission is changed for some particular entity or institution, obviously that can have a profound effect on the employees. They should be involved in some way.

Secretary DERWINSKI. Yes, but I believe, just to be realistic, that mission changes are more apt to occur when there are facilities reasonably close to each other in urban areas. I honestly do not feel that our facilities in rural areas should honestly be subject to major mission changes.

Chairman CRANSTON. Wouldn't you agree that there probably ought to be at least one member who has worked extensively as an employee in VA's health-care system?

Secretary DERWINSKI. If that category of person would also bring to us all the additional talent or leadership we were looking for, yes. I am not precluding anything. In a very broad sense, Senator, what I'd like to have is the most impressive list of medical leaders who have a practical understanding of the VA and who are respected in their professions and who would be able to articulate the progress in medicine that the VA must pursue in the next 10 to 20 years.

Chairman CRANSTON. In view of the significant percentage of VA patients who receive and are in need of mental health-care services, I believe it is important that mental health programs be represented on the Commission by a mental health professional. Will there be such a professional on the Commission?

Secretary DERWINSKI. Yes, we are keenly aware of that fact. May I say that our psychologists or psychiatrists and their related health professionals will be kept in mind as we structure the Commission.

Chairman CRANSTON. You indicate there presumably would be a mental health professional involved?

Secretary DERWINSKI. Yes.

Chairman CRANSTON. In view of the crucial role that nurses play in the hands-on care of virtually all veteran patients, I believe it is important there be on the Commission at least one nurse who has experience in or with the VA system, like somebody who has worked her way up as a nurse and spent 20 or 25 years and become the chief nurse in some entity. Will there be at least one such person presumably?

Secretary DERWINSKI. I think there is a very strong possibility. I'd look upon that as just a very practical fact.

Chairman CRANSTON. I think every committee should be made to appoint at least one former chief VA Chief Medical Director to the Commission. Do you have any reaction to that?

Secretary DERWINSKI. The only qualification I'd put to that is that person in that category should still be an energetic practitioner of medicine and considered up-to-date with all of the developments in medical care.

I don't think we are going to lack knowledge of the VA. We are going to staff this Commission effectively with some of our key people; we are going to have people from the medical world who, I think, have an appreciation and understanding of the VA or they won't accept the assignment. I think we will be well covered.

I didn't want to anticipate any of your questions, but the one thing I do want to stress is the first question I am going to ask of any would-be member of the Commission is whether or not they are going to give us some real time. We don't want figurehead commissioners, we don't want someone to show up at the first and final meeting of the Commission. We want active, hands-on commissioners, if I may use that term. We are going to want active participation and leadership from them.

Chairman CRANSTON. I think that sounds very good and it is a very laudable goal. You do want to make sure you have people

with great experience; maybe a Deputy Chief Medical Director would serve that purpose.

A table printed in your written testimony illustrates the resources by patients in differing age groups in high-use rehabilitation and high-use psychiatry. In estimating future needs, it will be necessary to take into account the unique characteristics of these particular age cohorts. For example, 68-year-old veterans—the average age of World War II vets today—require and use a very different mix of rehabilitation and psychiatry services now in 1990 than Vietnam era veterans would use in 20-plus years when they reach that age.

In your search for both commissioners and staff, what steps are you taking to insure that the Commission has adequate expertise available to factor in the anticipated changes in medical practice and technology?

Secretary DERWINSKI. I think in any field we approach, not just rehabilitation, but research, surgery, every phase of the medical treatment of veterans, we want the kind of description you just gave. We want the expertise, we want the leadership, we want the sensitivity. That's why, I might add, even though we have stated that the Commission would range from 9 to 15 members, I intend to have 15 in order to have the widest possible base of medical expertise.

Chairman CRANSTON. Thank you very much. Frank.

Senator MURKOWSKI. Mr. Secretary, do you feel that you have the authority now to close the VA facilities?

Secretary DERWINSKI. Technically, yes, subject to notifying the Congress.

Senator MURKOWSKI. You have to notify the Congress.

Secretary DERWINSKI. Yes, and then realistically, I would do so only after consultation with the appropriate State delegation. Frankly, we had the plan to move 10 people from one location to another in the State of a very prominent congressional leader and we were shot down. In another instance, we——

Senator MURKOWSKI. Ten people, you couldn't move 10 people?

Secretary DERWINSKI. We couldn't move 10 people. In another instance, Mr. Principi, who you know is a Naval Academy graduate and served with great distinction in Vietnam, went to face a large House delegation and he was in more danger there than he was at any time that he served on the battlefield.

Secretary DERWINSKI. That was a case of moving another 20 people, so we have no illusions. I've answered "yes" legally and theoretically, but in the practical sense, we look at it with much more caution.

Senator MURKOWSKI. I can understand based on your track record. [Laughter.]

In the area of moving 10 people, I can understand that you are looking over your shoulder all the time and probably are much more healthy when you don't even think about it.

In your professional opinion, as head of the VA, do you feel that there are certain facilities that should be closed?

Secretary DERWINSKI. I think there are definitely facilities where refinement of the mission, greater specialization, greater utilization of neighboring resources would be——

Senator MURKOWSKI. In other words, the idea is not to reduce the care but consolidate where it is practical?

Secretary DERWINSKI. Provide certain kinds of care much better.

Senator MURKOWSKI. You feel there are areas in which that should be done now?

Secretary DERWINSKI. Yes.

Senator MURKOWSKI. And you can identify those?

Secretary DERWINSKI. Especially in urban areas where history impacted on it over the time, we have a number of facilities reasonably close to each other. For example, we've got clusters of facilities in and near Boston, Chicago, the greater New York City area. There are certain refinements of medical care delivery that could be made for the betterment of veterans.

Senator MURKOWSKI. Rather than go into great detail on asking what the justification is or where these are, I assume in your professional opinion, the justification is warranted by the ability to provide a greater service capability in a general area without it being a deterrent to the health care. My question to you then is why don't you do it?

Secretary DERWINSKI. In some cases, we are. In some cases, we are moving slowly and methodically in that direction.

Senator MURKOWSKI. I guess my question is, this Commission, these two bills give you insulation but by the same token, you have the authority now and I gather you're waiting for the insulation to kind of get in place?

Mr. PRINCIPI. Historically, as you know, Senator, the VA has sent notification up to the Congress, pursuant to section 210(b) of the code, that we intended to close a facility or change the mission of a facility from an inpatient facility to an outpatient facility, to combine insurance centers and other similar proposals only to be blocked. It's almost an impossible task.

Hopefully the Commission, by taking an objective, comprehensive look at the entire system and the changes that need to be made nationwide, insulation plus the fact it's a total package may be easier to sell to the Congress. It's a process we hope will help us achieve this objective. We have tried and I am sure we will continue to try in the future but as the Secretary mentioned, we are trying to do some consolidation in the benefits area and it's been very, very difficult.

Senator MURKOWSKI. Knowing something of the Polish and Italian heritage, I am struck by the reality that an Irishman by the name of William Driver in 1965 closed six facilities and that's the last time that anything was closed. It's kind of interesting to relate to these metropolises where these facilities were located—Sun Mountain, NY; McKinney, TX; Fort Bayword, NM; Brooksville, OH; Dwight, IL; and Rutland Heights, MA. None of the big cities made the list.

Knowing of your perseverance and commitment I am sure that you wouldn't let an Irishman, even if it was in 1965, set a precedent that you folks wouldn't care to address. I think it is important to reflect on. Obviously we had significant concerns then from the urban areas because none of them are represented on this list. This is a pretty rural list.

Mr. PRINCIPI. That list, Senator, was much longer at the time it was submitted to the Congress and was weeded down to the six you've mentioned. [Laughter.]

It was a noble effort and hopefully the VA is better for closing some of those facilities. I don't know.

Senator MURKOWSKI. I assume that these facilities haven't been missed except in those communities perhaps and there hasn't been a reduction in VA health care as a consequence of these closures. And the system has not fallen apart as a consequence of these closures as some predict is the real motivation behind this effort.

Obviously the Senator from Alaska is attempting to neutralize that criticism but recognizes that he is not. He is probably fanning it.

Secretary DERWINSKI. But you do give us the opportunity, if I may phrase it in this fashion, that our goal is to improve medical service to veterans. If in the process, we are subject to ferocious and knee-jerk criticism, Tony and I intend to take it. We are big boys and we believe in the old adage if you can't stand the heat, get out of the kitchen. We expect a lot of heat but our strength is the strength of 10 or more because our hearts are pure.

Senator MURKOWSKI. Well, you bring a tear to my eye——

[Laughter.]

Senator MURKOWSKI. About the only thing I can do is join you by reminding you that misery loves company. [Laughter.]

Mr. Chairman, I have three more brief questions because I think we have softened up at least the witnesses. I don't know about the rest of the audience.

Mr. Secretary, both Mission Commission bills prohibit the Secretary from modifying the recommendations of the Commission. With respect to the administratively-created Commission will you comply with the legislative intent regarding this issue? That is, will you approve or disapprove in total the recommendations of the Commission? I could have written the question much simpler but I gather that what we're looking at here is whether you are going to turn down the whole thing when it comes in or whether you're going to piecemeal it or what. What do you have in mind?

Secretary DERWINSKI. I have no intention to nickel and dime the Commission. I intend to either look at it and say perfect job, or I intend to say, you've given me something I can't sell, it will be one or the other.

Senator MURKOWSKI. The second one is, will the Commission be asked to look at your unserved areas to determine if a new facility, either hospital or outpatient clinic, is needed? In other words, are you going to turn it around and look at the area to see if there are holes in it. Obviously, Alaska, we don't have a veterans hospital and we are not asking for one, I might add. Clearly it is a hole in that sense of the word.

Secretary DERWINSKI. Yes, and I think we keep in mind that we keep looking at the better locations for outpatient clinics, for outreach centers, and better locations even within a major metropolitan area. Nothing is precluded and that is a logical vehicle for review.

Senator MURKOWSKI. As I read it, both your bill and the one that I introduced limited the number of Commission staff which could

be VA employees. Therefore, I assume you thought that the staff would or should consist of non-VA employees. But administratively your Commission is all staffed by VA employees. I think the Chairman touched on that but maybe I wasn't paying attention.

Secretary DERWINSKI. Originally we had a somewhat different concept as to both structure and then also the implication of that Commission report when it came because our concept was taken from the DOD Base Closure Commission in the sense that Congress would have to take it or leave it. But because we had to establish it administratively, we selected Ms. Quandt who is the totally respected professional in the VA field, commands great personal support from our medical center directors, and everyone has worked with her. We intend to staff this Commission with some of our best people.

We are going to have a DOD and HHS employee assigned to us and if another additional expert or two is needed, there will be provisions for that.

Senator MURKOWSKI. So why are all of them VA?

Secretary DERWINSKI. Because they have the technical expertise to——

Senator MURKOWSKI. But do they have the objectivity?

Secretary DERWINSKI. I think they will because they will be drawn from different facets of the VA. They will be drawn from the ranks of various VA specialties.

Senator MURKOWSKI. Yes, but that begs the question of objectivity. That's the whole point of getting a balance, people who can come in and say, well, the VA specialist has a good point. They understand the nursing, surgical or so forth, but there is a time in motion here that clearly is out of sync.

Secretary DERWINSKI. But the staff will be providing technical backup. They are not going to be making policy. The policy and judgments decisions will totally be in the hands of the Commission. I won't be allowing and Ms. Quandt will not allow the staff to be spoonfeeding the Commission members.

Senator MURKOWSKI. Yes, but you still have VA employees on the Commission.

Mr. PRINCIPI. There will be VA employees on the staff of the Commission. On the Commission itself, there will be no VA employees. They will be outside the VA. The staff, the technicians, the datagatherers, the researchers who will be providing that information to the Commission——

Senator MURKOWSKI. The professional staff is confused about this, I am told, ours here.

Mr. PRINCIPI. Our professional staff to our Commission members will be VA employees. The Commission members themselves will be non-VA.

Senator MURKOWSKI. The Commission members themselves will be non-VA?

Mr. PRINCIPI. Correct.

Senator MURKOWSKI. Glad we got that squared away.

My time is up and I think I don't have anymore unspoken thoughts, so it is time to leave. I want to join with the Chairman in commending the commitment and fine work that Dr. John Gronvall has contributed to our Nation's veterans over the years. We

wish him the very best in his new area of endeavor and responsibility. It has been a pleasure working with you. I am sorry that I haven't gotten to know you on a more personal basis.

Dr. GRONVALL. Thank you very much.

Senator MURKOWSKI. Mr. Secretary and Mr. Principi, Mr. Carroll and Ms. Quandt, I thank you very much for your testimony. It will be interesting to see how the dialogue that we have had here is interpreted by our various organizations and the extent of the communication that comes back to me as a Ranking Member from my colleagues, on what the danger of unwinding the system and/or the realization of those of us who would like to think that we are making a contribution to the efficiencies of the system to provide a better degree of care to our Nation's veterans.

Obviously it is still swimming upstream and I wish you well, gentlemen. I appreciate your commitment to take the heat. It may be a long, hot summer.

Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you, Frank.

I want to allude to one bit of ground that was covered while Frank was asking questions. I arrived in the Senate in 1969 and got on the Veterans' Affairs Committee at once. I found it to be a system woefully unprepared to meet the critical needs of Vietnam veterans who started coming back in immense numbers and had already started back at that time, so I think it is worth noting that the prior closure in the 1960s came at the very time that the system was about to receive large numbers of wounded veterans and veterans who had all sorts of problems. I think we can be glad that more were not closed at that time. I am glad that we now don't seem to be in any such situation with seemingly a more peaceful world looming.

Tony, to followup on one thing you just said to Frank Murkowski, other than a proposal to effectively close one rural VA hospital, Walla Walla, what other section 210(b) submissions have been made for VA medical facilities, if any?

Mr. PRINCIPI. I am not sure, Senator. There were any——

Chairman CRANSTON. I don't think there's ever been any.

Mr. PRINCIPI. I think the situation surrounding Walla Walla and the morale after that, I think there would have been other section 210(b) submissions but they were just canceled because the handwriting was on the wall. I think the most recent problems further reiterate that point.

Chairman CRANSTON. I still have quite a bit of ground to cover, so I'll try to be brief and if you can keep your answers brief too, we can get through it all.

Throughout your prepared testimony, reference is made to an independent analysis or an outside group of experts. On page 9, the statement is made, "The Commission is to be intellectually, technically and professionally free to come in with whatever recommendations its wisdom and common sense can bring to us which will improve the VA health-care system." That's surely a commendable goal. However, other language in the testimony illustrates how close the Commission ties will really be to VA.

Appointment of members will be made by you and the Deputy Secretary's offices. You will receive ongoing briefings for policy

purposes. The executive director has already been selected and 29 of 30 staff members are to be VA employees designated by your office. Virtually all of the Commission staff will thus presumably want to continue their employee relationship with you and your representatives will control the staff's access to VA resources such as data bases, computer time and terminals, and consultant hiring authority. It also seems clear the Commission will receive extensive guidance from you.

Against this background, how do you plan to attempt to insure the Commission's independence and what can you do to counter the appearance that the Commission will be very much controlled by VA's agenda and VA's own employees who are directly accountable to you?

Secretary DERWINSKI. First, we intend to have as high a caliber Commission as acceptances from leaders in the medical field would dictate. I would never presume to take truly professional, medical leaders and attempt to dictate in any way their final judgments. I am going to be very, very comfortable with the talented group of people. I will remind them periodically there is one basic principle and that is, whatever you do, ladies and gentlemen, it's for the benefit of our customers, our veterans.

That part, Senator, I am not concerned with because I think our employees who will be working under Ms. Quandt will feel that they have been honored and privileged to be given that challenge. If anything, their careers will be enhanced, it will be a special contribution they will have been able to make.

Senator MURKOWSKI. Mr. Chairman, I'd just like to introduce into the record a March 20 Post—in the Health Journal of the Washington Post—an article diagnosing veterans hospitals.

Chairman CRANSTON. Fine. That will appear in the record.

[The Washington Post article follows:]

[From The Washington Post, Mar. 20, 1990]

DIAGNOSING VETERANS HOSPITALS

(By Bill McAllister)

Twenty-five years ago, Lyndon B. Johnson did something that no President since has dared suggest: He proposed closing 11 veterans hospitals and four old soldiers' homes.

The resulting bipartisan furor was so intense that Johnson was forced to retreat. In the end, he managed to close only seven of the facilities.

Sometime this spring, about 15 individuals, many of them health care professionals, will assemble at the year-old Department of Veterans Affairs and attempt to pick up where Johnson left off.

Under a plan crafted by former Congressman Edward J. Derwinski, now the first Secretary of Veterans Affairs, the group will be charged with plotting the future of the 172 hospitals devoted to caring for the nation's 27.1 million veterans. Theirs is the largest hospital system in the country and, according to congressional testimony, one of the most troubled.

Underfunded, understaffed and widely inconsistent in whom it treats, the veterans hospitals have managed to survive in the past quarter century, thanks not to any national health policy but to a pork-barrel system under which few members of Congress have been willing to question the viability of a hospital in another member's district.

VA officials have conceded that critical management decisions are often made in the field and often without their knowledge. They don't know, for example, how many veterans are treated at the hospitals each year; they do know how many times patients are treated, they just don't know how often it's the same veteran.

More important, they have conceded that the quality of care in the system has suffered in the past decade because the VA's medical budgets failed to keep pace with soaring costs.

To cope, hospital directors have shrunk the system without congressional approval, closing off whole wards in many hospitals. But they have avoided even the suggestion that some hospitals should be closed entirely. According to one former chief medical officer, they were always fearful that any such list would slip out of headquarters and provoke yet another fight with Congress and the fearsome veterans' lobby.

Now that may be changing. While Derwinski has promised Congress he won't let his review commission use the "C word"—closing—he is promising that, other than that, it will have a free hand. Its mandate will be to recommend to Derwinski by the summer of 1991 what he should do with all 172 hospitals.

VA officials point out that Derwinski's pledge to keep them open does not mean that the hospitals can't be converted into outpatient clinics, nursing homes, hospices, or day-care facilities for elderly veterans.

The issue is a critical one. Recent VA studies show that the number of veterans has begun to decline rapidly after peaking at 28.6 million in 1980. While the number of elderly veterans is increasing, by the year 2000 their overall number will drop to 24.1 million. By 2010, the year toward which the commission report will be aimed, it will fall to 20.5 million.

THE VETERAN POPULATION

[In millions]

	1980	1985	1989	1995	2000	2005	2010	2015	2020	2025	2030	2035	2040
Total	28,640	27,982	27,227	25,700	24,112	22,340	20,503	18,713	17,098	15,718	14,578	13,687	13,044
WW II	11,841	10,535	9,312	7,217	5,365	3,609	2,134	1,065	427	137	42	13	4
Vietnam	8,073	8,246	8,293	8,253	8,008	7,607	7,036	6,273	5,312	4,191	3,013	1,934	1,082
Post-Vietnam	989	1,984	2,784	3,993	5,103	6,233	7,348	8,408	9,386	10,251	10,969	11,512	11,877

Note: Figure for 1980 is from the 1980 census, 1985 and 1989 are estimates, 2000 through 2040 are projections.
Source: Department of Veterans Affairs

Last week, when Derwinski went before the House Veterans Affairs subcommittee on hospitals, he got an unexpectedly warm reception, one that could signal a new willingness by Congress to recognize that the hospital system is in need of acute care.

Just as remarkable was that by the time the brief hearing ended, it was the representatives of veterans organizations—not the VA—that were on the defensive.

As Rep. Bob McEwen (R-Ohio), the ranking Republican at the hearing, noted, the question is whether the federal government should "maintain some empty hospitals in South Dakota when veterans elsewhere aren't being served."

Derwinski sought to assure the subcommittee that his intentions were good and that he wasn't targeting the small, rural VA hospitals, ones that may be the most vulnerable to any critical review. "I did not become the Secretary of Veterans Affairs to preside over the dismantling of the VA," he said.

But the hospitals have not been subjected to a "broad, thoroughgoing review in 25 years," and Derwinski said the changing veterans population mandates "a totally honest, full analysis."

Representatives of the major veterans organizations, some of whom have called for such an analysis in their annual review of the hospitals, gave the commission qualified endorsements.

"We have seen that such terms as 'mission realignment,' 'consolidation' and 'management efficiencies' are often actually euphemisms for closing VA hospitals and generally reducing services to veterans," said Dennis M. Cullinan of the Veterans of Foreign Wars. "These past attempts to surreptitiously reduce rather than refine the VA health care system should serve as a warning to all of us now to proceed with great caution."

However, Rep. G.V. (Sonny) Montgomery (D-Miss.), chairman of the full House veterans committee and the man who last year blocked Derwinski's call for a congressionally mandated study of the hospital, offered his support for the review. Montgomery said he didn't like Derwinski's initial idea that Congress would have to accept "all or nothing" from the review commission.

But Montgomery also promised that "Congress must also play a role in the future of the VA health care system," indicating that he expects to review the commis-

sion's recommendations. Moreover, he warned the VA that its commission must alert local communities to what should happen to their hospital.

That didn't happen when Lyndon Johnson acted. This time, the VA plans to make projections of the veterans population to the year 2010 in the areas served by each of the hospitals, a step that should give the department something it has never made: a strong argument for which of its hospitals are the most needed.

Chairman CRANSTON. If the Commission wanted to bring in some outside, that is, non-VA staff to counter perceived bias on the part of VA staff, what would your reaction be?

Secretary DERWINSKI. No objection except that I would tell you quite honestly I don't expect our staff to be biased. I expect them to be professional.

Chairman CRANSTON. I said perceived; some people may perceive that. So then you'd let them hire whoever they wished if that became their feeling.

Secretary DERWINSKI. Yes. We want the Commission well serviced.

Chairman CRANSTON. What if the Commission wanted to hire a deputy executive director from outside the Department, would you agree to that and give the Commission free rein to select that person?

Secretary DERWINSKI. I am not going to say no to anything reasonable the Commission wants, subject, I suppose, to basic budget restraints that we want to live with. Again, I have to return to the central point which is we want a totally effective Commission to produce an effective, forward-looking recommendation. We will counter the perceptions, if we have to fight a lot of the perceptions. We will take them on but we are going to have a scrupulously clean Commission.

Chairman CRANSTON. Then you obviously would give consideration if that's what they ask?

Secretary DERWINSKI. I am not precluding anything that is reasonable.

Chairman CRANSTON. On page 16 of your statement, you note that consultants will be hired for purposes of data analysis. Will these consultants be hired by the Commission or by VA?

Secretary DERWINSKI. They will be presumably selected by the Commission, but obviously technically at that point, hired by the VA but selected by the Commission.

Chairman CRANSTON. I gather from the comments on page 18 of your testimony that you have now abandoned your proposed legislation to establish the Commission. Is that correct?

Secretary DERWINSKI. Yes, that was the reality Senator Murkowski was stressing earlier.

Chairman CRANSTON. Although I understand the political reality that led to that, and I alluded to it earlier, I want to reiterate the skepticism I expressed in my opening statement this morning that an administratively-established Commission can be effective in the sense of producing a report that will receive wide support for implementation.

Knowing the Congress as well you and Tony do, Ed, what gives you confidence that it will be possible to gain support from the members of the congressional delegation when a VA facility in the

delegation's jurisdiction is recommended to undergo a major mission change that will result in a diminution of resources there?

Secretary DERWINSKI. My feeling was that just because we couldn't get the legislative approval was no reason for us to shirk the responsibilities that we feel are there. We feel this Commission is absolutely essential and we're willing to run the risk of whatever congressional complications we will face when we produce this final package.

Chairman CRANSTON. Would you please describe OMB's role in the inception of the idea for S. 1398, which was the Administration's proposed legislation to establish the Commission and then in the inception of the proposal that you acted administratively to appoint a study Commission? What part did OMB play in both phases?

Secretary DERWINSKI. No real part. Just routine communication but this is entirely a concept we developed within the VA primarily as a result of some hard work Tony put into the effort.

Mr. PRINCIPI. We cleared the legislative initiative with OMB prior to submitting it to the Committee.

Secretary DERWINSKI. But that was routine.

Chairman CRANSTON. I regret to say I've just been handed a note that says the Cloak Room says the Republicans have objected to all committees meeting today and we were supposed to stop 5 minutes ago. I guess I'd be in violation of the rules if we proceeded, unfortunately, and I apologize, particularly since some people wonder why they came all the way from California to be here this morning. I don't know how we handle that.

I might be able to go to the floor and get permission to continue. I'd be glad to attempt that, so why don't we recess now. That will mean I won't have quite as much time to continue all of this because I have to be somewhere else at 12:15 p.m. We will stand in recess and I'll see if can correct that.

[Recess.]

Mr. STEINBERG. May I have your attention?

I have been trying to reach Senator Cranston and have not been able to do so, but, in light of what I know his schedule is at this point, I am going to say that we are going to have to call it off for today.

I know that his initial efforts to get consent were rejected on the floor and I guess he was trying to work out something with those who were objecting. The objection was, I believe, coming based on proponents and opponents of the Clean Air Bill and various aspects of it wanting to have members on the floor. I very much doubt he's going to be able to get consent. He was trying, if he possibly could, at a minimum, to get consent so that the out-of-town witnesses would be able to appear, but it just does not appear that is going to be feasible.

I feel very reluctant to ask anybody to remain here any longer on the very outside chance that he might get consent, and I don't think we'd have much more of Senator Cranston's time, given his schedule at this point anyway.

What we will attempt to do is to reschedule for an early morning next week, possibly Wednesday or Thursday, but we will be in touch with each of you. I realize that many of the out-of-town wit-

nesses may not be able to return, and we greatly regret the inconvenience that you are caused. This is something that is just beyond our control. In all my time here, I think this is only the second time it's ever happened, so we apologize.

We thank Midge and the other Department people who waited around as long as they did to hear the other witnesses. We appreciate that very much. We will be back in touch with each of you. Jim, Jack, Tom, and Dave, we're sorry.

Senator Specter has just arrived and indicated this may be worked out and he's apparently willing to stay for 1 or 2 minutes and see if it does work out, so if I could ask you just to bear with us for another couple of minutes, we will see if something does get worked out. I am sorry I was premature.

Senator SPECTER. I have asked Mr. Steinberg to reconvene for the purpose of saying that a consent may be granted. I was on the floor when Senator Cranston, the Chairman, came to the floor. I was offering an amendment on the Clean Air Act and he asked for leave to speak, which I agreed to, to try to get unanimous consent to proceed with the hearing.

I left the floor just a few minutes ago and Senator Cranston was still there and now he's on the telephone.

Mr. STEINBERG. He's calling in right now. He says the same as you, that we may get consent.

Senator SPECTER. Many witnesses have come from great distances and it would be very unfortunate if the hearing did not go forward if there is any possible way to have it go forward. I came right over when we finished my amendment on the Clean Air Act and stopped at another Health and Human Services hearing, so I wanted to let you know that. Now Senator Cranston has confirmed that.

My hope would be that witnesses would stay. I regret that I have other commitments but someone will come back to chair the hearing and hear the witnesses and I hope the technicality will not prevent the hearing from going forward. What do you think, Jon?

Mr. STEINBERG. Senator Cranston thinks it is possible.

[Whereupon, at 1:30 p.m., the hearing was discontinued, to reconvene at 9:15 a.m. on Wednesday, April 4, 1990.]

PROPOSALS TO EVALUATE THE FUTURE STRUCTURE OF THE DEPARTMENT OF VETERANS AFFAIRS HEALTH-CARE SYSTEM

WEDNESDAY, APRIL 4, 1990

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to recess, at 10:20 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (Chairman of the Committee) presiding.

Present: Senators Cranston, Murkowski, and Thurmond.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. Good morning to you all. This morning's meeting is a continuation of last week's interrupted hearing. As you know, we were forced to discontinue that hearing after less than 2 hours due to a Republican refusal of unanimous consent for committees to meet that day.

Today we welcome back the four panels and look forward to hearing their uninterrupted testimony on the various proposals—two legislative and one administrative—for reviewing and restructuring the VA health-care system.

Due to scheduling problems, there have been a few changes in the witness list since last week. We switched the order of the panels so that Dr. Butler can catch a plane later this morning. In addition, Dr. Wendell Musser of the Atlantic VAMC was unable to return for this hearing. We'll be sending him written questions and his written statement will appear in the record.

[The prepared statement of Dr. Musser appears on p. 146.]

Chairman CRANSTON. We greatly appreciate the patience and understanding of the witnesses who were preempted last week and thank you all very much for arranging your plans to return this morning, particularly those witnesses from out of town. We regret the inconvenience that was caused to all of us, but to you particularly.

My longer written statement is available on the table with the statements of the witnesses. When we were interrupted last week, I was asking questions of the panel of VA officials. I will continue relatively briefly with those questions, and then we'll hear from the other witnesses.

Our first panel is made up of Deputy Secretary Tony Principi, who is accompanied by Chief Medical Director John Gronvall and

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Marjorie Quandt, the Executive Director of the Secretary's Commission on the Future Structure of VA Health Care.

So, picking up where we left off last week, Tony, what are your views on my proposal at last week's hearing to transfer to MAMOE the necessary funding for the Commission in fiscal year 1990 and fiscal year 1991 from third-party reimbursements rather than from medical care or from minor construction?

STATEMENT OF HON. ANTHONY J. PRINCIPI, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR; MARJORIE R. QUANDT, EXECUTIVE DIRECTOR, COMMISSION ON THE FUTURE STRUCTURE OF VA HEALTH CARE; AND RAOUL L. CARROLL, GENERAL COUNSEL

Mr. PRINCIPI. Mr. Chairman, we prefer to take the funding from the medical care account. We'll look at any funding source that the Committee desires us to look at, but it is the Administration's position that we would use money from the medical care account.

Chairman CRANSTON. What is the reason for that?

Mr. PRINCIPI. We believe that's the most appropriate account to address the Commission.

Chairman CRANSTON. Ms. Quandt.

Ms. QUANDT. The end result of this Commission is patient care, and to the extent that it is veteran and patient care, we consider that the most appropriate, when one looks at the size of the account. The medical care account is far larger than GOE or any other account such as construction, and therefore we think there's more flexibility here.

Chairman CRANSTON. The House Appropriations Committee proposed—and the House last night passed—H.R. 4404, a provision to transfer $600,000 from VA's minor construction account to MAMOE in fiscal year 1990 in order to provide partial funding of the Commission in the current fiscal year. Your proposal had been to transfer that amount from the medical care account. In either event, the transfer would recover only $600,000 of the $897,000 in estimated fiscal year 1990 costs.

Thus in followup question 11F that I sent you last week, I asked what specific functions will be reduced this fiscal year under MAMOE, medical care, and GOE in order to fund the Commission. Your response stated that under the House proposal, the medical care and MAMOE appropriation will be reimbursed, allowing positions vacated by employees' assignments to the Commission to be filled. Since the $600,000 reimbursement from minor construction is $107,000 less than the total $707,000 in medical care and MAMOE costs you project for the Commission in fiscal year 1990, the reference in your answer to reimbursement seems only partly correct.

Can you tell us now specifically what medical care and what MAMOE activities will be reduced to provide for Commission costs in the current fiscal year?

Mr. PRINCIPI. I envision that no activities will be reduced as a result of the funding.

Chairman CRANSTON. There is a difference of $107,000. Where is that going to come from?

Ms. QUANDT. Mr. Chairman, the difference that is shown in what was on the budget as we project the budget, and what will be reimbursed, indicates that GOE is not to be reimbursed, so that figure has been subtracted out.

Mr. STEINBERG. According to the data that you've provided us and our understanding of it, GOE is not included in the $707,000 total. The total with GOE, as we understand it, is $798,000, so that leaves a difference of the $107,000 that Senator Cranston referred to between the $707,000 in total medical care and MAMOE costs, on the one hand, and the $600,000 that you were seeking to be transferred, on the other.

Do we misunderstand the figures in some fashion?

Ms. QUANDT. I do not believe you misunderstand the figures. I think there is also a question in the mind of our budget officer as to, when we receive a supplemental, if we will be able to pay back the full amount as is shown, meaning that a supplemental may come at a date when it is not possible for MAMOE or medical care to expend that, so they have allowed for a portion of that.

Chairman CRANSTON. I think that's a rather innovative answer to our question.

With respect to the Commission's support to be provided from GOE you stated, "no reimbursement is required. Generally GOE staff offices will be requested to provide support services consistent with their general responsibilities." This means that offices funded under GOE that are called upon to assist the Commission will be required to provide the needed services out of their existing resources without being reimbursed. Is that correct?

Mr. PRINCIPI. That is correct. Their support services will be consistent with their general responsibilities.

Chairman CRANSTON. Thank you.

Your response also stated, regarding GOE, that "in most cases other analysts are assigned the duties of vacated positions. Hiring the new employees will be expedited as necessary."

What is meant by the term "vacated positions" and how would the hiring of new employees be paid for if GOE is not going to be reimbursed?

Ms. QUANDT. Your question, Mr. Chairman, was what is meant by the "vacated position"?

Chairman CRANSTON. And how would the hiring of new employees be paid for if GOE is not to be reimbursed?

Ms. QUANDT. If GOE is not reimbursed, those positions can be what we call "back-filled" only to the extent that there is none available in GOE. If there is not money available, then they would not be "back-filled" and some other analyst picks up that work.

Chairman CRANSTON. Would there ultimately be a GOE cost that would not be reimbursed?

Ms. QUANDT. Not to my knowledge, no.

Chairman CRANSTON. Your fiscal year 1991 budget request includes $439,000 in the medical care account for the Commission. After the budget was submitted, VA's General Counsel concluded that medical care funds may not be used for the Commission and your estimate of the fiscal year 1991 costs rose to $3.4 million.

Please describe your current plans for funding the Commission in fiscal year 1991, and specifically the source of funds.

Ms. QUANDT. Again the source of funds will be from medical care as determined by the budget request and our determination that medical care is the most appropriate fund which will then be transferred into the MAMOE account.

Mr. STEINBERG. What will the total amount be?

Ms. QUANDT. The total amount for fiscal year 1991?

The total amount for fiscal year 1991 would be $3.4 plus million.

Mr. STEINBERG. So that means that there will be a need for the medical care account to absorb approximately $3 million since there was only $439,000 requested in your fiscal year 1991 budget request. Is that correct?

Ms. QUANDT. That is correct.

Mr. STEINBERG. And that $3 million would then be transferred along with the $439,000 presumably to MAMOE in view of your determination on that.

Thank you, Mr. Chairman.

Chairman CRANSTON. Senator Thurmond, I realize that you may have other time commitments. Do you have any statement or questions you'd like to make?

Senator THURMOND. Thank you very much, Mr. Chairman. I am in another committee and soon I will return there.

I just ask you now, Mr. Chairman, that the short statement by me follow your statement in the record.

Chairman CRANSTON. Without objection, your prepared statement will appear in the record.

Senator THURMOND. And I want to commend these people for coming here, and my deep interest in what they're doing. I think they're on the right track, and I'll back them to the fullest.

Chairman CRANSTON. Thank you, Senator Thurmond.

Senator THURMOND. Thank you.

[The prepared statement of Senator Thurmond appears on p. 120.]

Chairman CRANSTON. Tony, as you were advised would likely be the case, I have a few followup questions regarding the pending proposal to reorganize VHS&RA's management structure. In S. 2103, the Administration requested bill, allows this reorganization to go forward before October 1.

On March 16, VA's congressional relations office forwarded to me a decision paper which refers to the establishment of regional division offices as part of the VHS&RA reorganization. In that document, the regional division offices are described as 16 new offices and they're generally to be located in places where some of the 27 medical district offices were located.

March 16 was the first time that this Committee was informed by VA of the regional division office units to be established under the pending reorganization.

Why was there no information about the regional division office units in the original detail plan submitted on January 22? Would you also please describe the genesis of the regional division office proposal?

Mr. PRINCIPI. In our original submission to you, Mr. Chairman, we did not describe the outstationing of certain regional office per-

sonnel as regional division offices. However, I believe that as part of our section 210(b) submission we indicated that there would be certain outstationing of regional office personnel.

During the course of our discussions in putting together our plan for the reorganization, we came upon the term "regional division offices." Those offices would be colocated, to the extent possible, on the grounds of VA medical centers. They will assist the regional director in the carrying out of certain technical functions, such as fire and safety, planning, Medipro, and quality assurance. We have provided for the clarification to the Committee, as requested, by staff detailing the responsibilities and the locations of those offices. We request that it be made part of our section 210(b) submission.

Chairman CRANSTON. When was it decided that there would be regional division offices?

Mr. PRINCIPI. We decided at the time that the Secretary made the decision on the reorganization that we would have outstationed regional office personnel. The term "regional division office" came about just recently.

Chairman CRANSTON. What steps will VA take to clarify the January 22 plan formally so as to reflect the existence and role of the proposed regional division office units?

Mr. PRINCIPI. Excuse me, Mr. Chairman. We will dispatch to you a letter asking that it be made a part of our original submission.

Chairman CRANSTON. When do you think we can expect that?

Mr. PRINCIPI. Very soon, Mr. Chairman. I'll have it to you forthwith.

Chairman CRANSTON. Briefly, now, and in more detail for the record, would you please provide a description of the role of regional division offices?

Mr. PRINCIPI. The regional division offices will perform certain technical functions for the region. They include such functions as fire safety, planning, quality assurance, and other responsibilities as directed by the regional director.

Dr. Gronvall, would you add to that?

Dr. GRONVALL. No, I think those are the most important functions.

Again to perhaps repeat a part of what Mr. Principi said earlier, from the very outset, as the regional reorganization was developed, it was clear to us that certain functions could best be done by staff reporting to the regional director, but not located in the regional headquarters. The regional division office concept is, as he said, a more recent one, but would pull together in an office located at a medical center, some of the key staff conducting fire and safety inspections, doing planning, and quality assurance functions for the hospitals that are geographically close to the regional division office.

All of the staff in those offices will be part of the regional office responsible to the regional director. Staffing in such offices would be geographically deployed for the purpose of having them close to the medical centers where their function is carried out.

Chairman CRANSTON. Will there be an individual at the head of each regional division office who might be given the title of coordinator, for example, and whose role would be to coordinate long-range planning in the regional division office area and to consult

with State health agencies and service organizations, elected officials, and others regarding such planning and regarding the service needs of veterans in the area and how they might be met most effectively?

Mr. PRINCIPI. Mr. Chairman, we believe very strongly and support and encourage hospitals in a geographic area to network, share, and coordinate their activities. We certainly encourage the concept of informal networking.

However, we don't believe that there needs to be a formal structure to accomplish that, nor do we believe that we have to have someone who is officially designated with the responsibility of serving as the coordinator. We believe that function will be carried out, but we would like to leave that to the hospital directors in the given location, and to the regional directors, to encourage that type of activity. We're looking at that very carefully now, and we want to encourage that.

Chairman CRANSTON. It's my understanding that Senator Graham feels very strongly that there should be someone in charge to that degree. Is that really a final word on this, or is it something that's still evolving?

Mr. PRINCIPI. No, it's not a final word. As I stated, we feel very strongly about the need to continue that kind of dialogue among the hospitals in a given geographic area, for example, the role that Malcom Randall has played in Florida. We believe that he will continue to play that important role of facilitating communication in the Florida area and articulating those concerns and needs to the regional director through the regional division office.

The question of having one individual serve as a full-time coordinator in the regional division office—at this point in time, we don't believe that is necessary. But again, we support the concept.

Chairman CRANSTON. In effect you're saying that there won't be any such individual?

Mr. PRINCIPI. In the regional division office, Mr. Chairman, at this time we don't foresee a regional division coordinator. That is correct.

Chairman CRANSTON. Tony, onto another matter—as we all know, there's been a lot of discussion lately about the Department's high level, high priority review under your leadership of eligibility of VA benefits which the Secretary described to me in a letter dated February 27.

One of the most controversial issues this VA review panel has been addressing is eligibility for disability compensation. Wouldn't you agree that it would raise major policy questions if VA compensation were restricted to only those injuries or diseases incurred in the performance of military duties, or if eligibility for compensation was otherwise limited, without making parallel changes in the eligibility and criteria for military disability retirement?

Mr. PRINCIPI. Yes, I do, Mr. Chairman, and we are addressing that issue within our group. We feel very strongly that we need to take a look at the military disability retirement program, the interrelationship between the two programs, the need for two separate and parallel programs, and the question of whether those two programs should be combined. I think part of any proposal that we submit to the Secretary would have a provision that would require

a high level commission to look at the interrelationship between those two programs because whatever changes we make in service-connected disability would certainly have an impact and we want to make sure that we address both of them. So I fully concur with you, Mr. Chairman.

Chairman CRANSTON. Are you taking any steps now to coordinate this review with the Department of Defense?

Mr. PRINCIPI. We have not formally met with the Department of Defense, but we intend to do so. We also intend to have Department of Defense officials brief our group on the Department of Defense Retirement Program, yes sir.

Chairman CRANSTON. Thank you.

The Medical Follow-up Agency has been drifting while awaiting a response to its and my plea to VA, NIH, and the Department of Defense for core funding. I have not yet received a response from the Secretary to my January 18 letter, or to my followup question at our February 23 budget hearing. I understand that NAH has recently committed $65,000 for this purpose. Can you please pursue this issue actively? I would appreciate an answer as soon as possible, and a positive one if that could be the outcome.

Mr. PRINCIPI. We shall dispatch a response to you very shortly, Mr. Chairman. We have some concerns with regard to the VA being involved with core funding for this group. We believe that the importance of reviewing projects and funding those projects to the tune of $750,000 a year. However, unrestricted funding for core support is something that we're concerned about. I will ask Dr. Gronvall perhaps to add to that.

Dr. GRONVALL. We have drafted a response to you and hope to get it to you soon. I think the only question I would raise is that we have been entirely unable to find any record that the National Institutes of Health has indicated its willingness to provide support. There is recent congressional language in a committee report asking the National Institutes of Health to take the responsibility of lead organization working with the Defense Department and with the VA to address the issue of provision of core support. But I am unaware of any commitment.

We have, within the past week, discussed that question with officials at the National Institutes of Health, the Defense Department, and I've talked to officials at the Institute of Medicine, the organization at the National Academy of Sciences that houses the Medical Followup Agency.

Chairman CRANSTON. We understand that NAH has committed $65,000. I think it's very important work, and I urge you to get it nailed down as fast as you can.

Dr. GRONVALL. Perhaps as a followup to the hearing then, we could meet with the staff of the Committee to be sure that we understand how the commitment was weighed and where, because our information is different.

Chairman CRANSTON. I would urge you to do that.

Dr. GRONVALL. I would appreciate doing that.

Thank you.

Chairman CRANSTON. Thank you.

As you know, Tony, I also referred, during the February 23 budget hearing, to several other issues covered in letters that have

been pending with VA officials for some time including regulations for VA's use of Medicare's prospective payment system, which have been delayed for over a year and a half. I still haven't received responses to those questions. Can you please let me know by the end of this week when VA will provide responses?

Mr. PRINCIPI. We shall, Mr. Chairman.

Chairman CRANSTON. At the February budget hearing, Secretary Derwinski and you, Tony, Jo Ann Webb, and I discussed the situation at the Fort Rosecrans National Cemetery in San Diego. As you know, the cemetery's appearance has deteriorated, its grass has turned brown, and adequate watering has not been maintained due to the drought in southern California, and a shortfall in VA funds for water which the cemetery buys from the nearby San Diego Navy Base.

At our February hearing, you agreed to see if there isn't some way to work with the Navy to save the grass and improve the cemetery's appearance. Can you please tell us whether any progress has been made in getting water during the current fiscal year?

Mr. PRINCIPI. Yes, Mr. Chairman. Water to the Fort Rosecrans National Cemetery is currently provided by the Navy. However, we pay very high rates for that water and we're negotiating with the Department of the Navy in San Diego to reduce those rates. Therefore, we could perhaps continue that watering through the dry season.

We are negotiating with them, and we will continue to do so.

Chairman CRANSTON. Is there water at the end of the tunnel? [Laughter.]

Mr. PRINCIPI. Maybe we can desalinate the ocean water. The Navy does a good job of that aboard their ships. Perhaps we could set up some units at Fort Rosecrans. We will continue. Yes, there is water at the end of the tunnel.

Chairman CRANSTON. Good. Please keep after it.

Finally, Tony, I have one question that Senator Baucus requested that I ask reflecting the strong belief that the Commission should not overlook the rural element in VA health care. The question is, will the Commission include a member with substantial experience and background in rural health?

Mr. PRINCIPI. I can assure you, Senator Baucus, and members of the Committee, that we will have such a person on the Commission.

Chairman CRANSTON. Thank you very much.

Mr. PRINCIPI. Thank you, sir.

Chairman CRANSTON. That concludes my questioning.

Frank.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

Good morning, ladies and gentlemen.

Mr. Chairman, I appreciate you rescheduling the hearing. I know it's inconvenient to our witnesses as well as the staffs and the audience, but I do believe that the necessity of pursuing the establish-

ment of the so-called "Mission Commission" is most worthy of an extended hearing.

This independent Commission, which is now being established under the Secretary's administrative authority, will examine the VA's medical care system to determine if mission changes, realignments, or other changes are needed.

As was stated previously, I'm most supportive of this effort. I think it's appropriate that we examine our VA system. There's been some feedback to me that some may be distressed at the idea of examining the VA facilities, and potentially closing some that are not needed. I really don't believe that position is supported by the veterans of America.

I think that the veterans and taxpayers of this country feel that Government programs should be examined periodically to make sure that the American taxpayer is really getting his moneys worth, that we are getting the very best possible service available. And if there are indeed programs that are redundant, programs that cannot stand the light of examination, then indeed they should be terminated.

If we look at the difference between the two bills, S. 1332 and S. 1398, the only difference of significance is that in S. 1332 the Commission "may" recommend closures and in S. 1398 the Commission "may not" recommend closures.

I think this is an extraordinary issue in the sense that all we're talking about is whether if we find a redundancy, a situation that's not needed, or that the services are theoretically not in the best interests of the veteran in the sense that you could shut down a facility and combine it with another facility and provide better service, then that is what we should do.

I know the politics of the issue. I understand that the veterans' organizations are very sensitive about this, but I think that the American taxpayer is also sensitive about this kind of Government that offers an internal level of protectionism. It would be interesting to see just how this works out, but the realization is that the last closure of a VA hospital was in 1965, 1966, or 1967 (the list has been submitted for the record). They were small, rural hospitals that obviously weren't needed.

[The list of VA hospital closures follows:]

Clinton, IA
Dwight, IL
Fort Bayard, NM
McKinney, TX
Rutland Heights, MA
Sunmount, NY
Thomasville, GA

Senator MURKOWSKI. There are still a few today that might not be needed. What we're faced with here is a psychology that suggests that in a veterans area, if we do find anything that's redundant, anything that's not needed, anything that can't be adjusted in such a way as to consolidate, we simply can't do it. The Senator from Alaska just doesn't believe in that type of internal protectionism in Government services. I think the veterans of this country feel this same way, recognizing that the word "may" isn't "must," and in all candor, I think it's fair to say that the Secretary of Vet-

erans Affairs, a relatively new position, has observed the internal operations of the VA and has come up with a Commission mission to try and address the necessity of making changes.

I implore the veterans' organizations not to take a negative stand on the issue. Take a look at the merits of whether we can provide better services for American veterans with the money that we're ultimately going to have—which is never going to be enough—so that we can reprioritize and get on with the business instead of internal fighting and the threat that somehow the Administration, somehow the Secretary, somehow the Senator from Alaska, somehow some Republicans are trying to gut the veterans programs.

That is not factual, so I would hope that my little tirade this morning at least brings the topic up to a level where we can discuss it on its merits, as opposed to emotionalism. I would much rather face up front the objective of this legislation, which the Administration may be looking at from the political nuances of how they can get there from here, and the realization that perhaps they don't feel that they can make any changes under my bill because it says you may close if indeed it's worthy of providing higher levels of service, as opposed to the other piece of legislation which simply says that the Commission may not recommend closures.

I have just a couple of questions, Mr. Chairman. Mr. Principi, what should the role of the veterans' service organizations in the establishment and operation of the Commission? Should, in your opinion, representatives of the groups be members of the Commission? If so, how would you propose that kind of a balance?

Mr. PRINCIPI. Clearly the views, concerns, and recommendations of the veterans' service organizations could be represented on the Commission and we will have one consumer veteran advocate or more on this Commission. I envision the Chairman of the Commission being a strong veteran advocate and representing a number of veterans' service organizations. The representation of the Commission is clearly up to the Secretary. No decisions have been made, but we can assure you, Senator Murkowski, that their voice will be heard and represented on the Commission.

Senator MURKOWSKI. So you really haven't got a panel or a parameter?

Mr. PRINCIPI. With only 15 members and the needs to address the diversity of the VA health-care system, health-care planners, health-care economists, health-care practitioners, doctors, nurses, the various specialties, rural health care, places such as Alaska, New England, as well as the inner cities, the rust belt, and the need to ensure that we have that diversity, and only 15 members of the Commission, you can only accommodate so many. But we believe very strongly on the need to have someone identified as a veterans' advocate on the Commission. The numbers are just not settled yet.

Senator MURKOWSKI. Would you propose that the veterans groups themselves collectively nominate or present somebody recognizing that you can't possibly have all the veterans' organizations represented there, but certainly you should have representation from the veterans' organizations?

Mr. PRINCIPI. We've solicited their suggestions and we've spoken with them about it on several occasions. I know that the Secretary has discussed this issue with the leadership of the various veterans' service organizations. Whether they submit one nomination or more collectively or individually, that's their decision.

However, I have spoken with the executive directors and they have provided me with names of individuals they would like to see sit on this Commission. I've presented those to the Secretary.

Senator MURKOWSKI. Have you gotten any feedback from the veterans' organizations on what they feel the input of the organizations should be on the Commission to any degree of definitiveness?

Mr. PRINCIPI. I've received names of individuals whom they would like to see sit on the Commission. I've heard from one executive director who believes that the leadership of each of the major service organizations should be ex officio members of the Commission.

All of that is under deliberation at this time by the Secretary. We are considering all of the views and suggestions. No decisions have been made.

Senator MURKOWSKI. How do you see your role on the Commission, Mr. Principi, as Deputy Secretary?

Mr. PRINCIPI. I have no official role on the Commission. I see myself as a principle advisor to the Secretary. I intend to meet periodically with the Commission's staff director, lend my office's support to the Commission—both to the members and the staff—to help facilitate the work of the Commission, to help them achieve their objective within the stated time for the Commission's deliberations and recommendations to the Secretary, and assist them in putting together a strategy to present those recommendations to the Congress.

Hopefully they will receive favorable consideration. So I will not play an official role, but one more of as a policy advisor to the Secretary.

Senator MURKOWSKI. Do you see that as comparable to an ex officio, similar to the position that would be represented by members of some of these service organizations if they were on the Commission?

Mr. PRINCIPI. No, sir. I see that role as a quite different one. I will not be attending Commission hearings and meetings. I see myself more as sitting in with the Secretary to discuss periodically the work of the Commission, how they're proceeding, what additional support they might need, change in direction, guidance from us—more as a sounding board, if you will, to the Secretary.

Senator MURKOWSKI. I concur. I think it's much more effective if the Commission has the objectivity.

My last question, however, is how can you as Deputy Secretary, and I suppose comparable to a chief operating officer—as you have to carry out the recommendations under the call and direction of the Secretary as the structure is set up—address the dilemma of supporting the Administration's bill S. 1398 which says that this Commission can't recommend closure?

We are aware that the Secretary has the authority for closures now, subject to, obviously, congressional oversight. It seems to me that the whole philosophy of the Commission is potentially smoke

and mirrors here. We're setting up the Commission to recommend efficiencies, but we're saying at the same time that if we come down with a scenario that shows there are inefficiencies and that there should be closures, we can't close them.

I don't know how you can possibly carry out the responsibility of a dutiful—I won't say servant in the sense of the word—but carrying out the responsibility to provide the very best of services under this kind of a dilemma.

Mr. PRINCIPI. First, let me say, Senator, I understand the point you're making. However, I do believe that much can be done to improve the efficiency and delivery of health care that we provide short of closure. All facilities will be studied. And I'm sure that the Commission will recommend major mission changes for certain facilities, and program changes.

Senator MURKOWSKI. What does that mean, though? A program change is that we don't need that program anymore. What does that mean to you?

Mr. PRINCIPI. We may have a geographic area of this country that has two, three, or four tertiary care hospitals within a relatively short distance of one another. They exist in the system, we all know that. I could see the recommendation that one or more of those tertiary care hospitals should have a complete mission change, that one should be an extended care facility.

Now we're not closing that facility, but we're using that resource to help us deliver a continuum of care to our Nation's veterans from preventive health care all the way to hospice care.

We'll have a tertiary care medical center delivering the high tech surgery and programs for those veterans, but down the road what was once a tertiary care hospital may be a combination outpatient clinic where minor surgery can be performed and many of the——

Senator MURKOWSKI. I understand.

Mr. PRINCIPI [continuing]. Beds converted.

One could argue that we should just close that facility completely and put a "for sale" sign up. Maybe there are some good arguments to do that, for example, to save those resources and move them to another geographic area where the demographics show that we have an increase in the veteran population. But I do believe that, short of closure, we can achieve the objectives that I think we all aspire to with regard to this Commission.

Senator MURKOWSKI. I think that's a good explanation, but you can do that anyway without a Commission.

Mr. PRINCIPI. We can, but then we have to do it on an individual hospital-by-hospital basis. We felt that getting this blue-ribbon Commission, well-representative in varying disciplines and expertise, and then presenting this as a package to the Congress under the section 210(b) notification and wait requirement, is a more logical and thoughtful approach. But there's no question that these are the kinds of things that we do have the authority to do.

Senator MURKOWSKI. I understand the politics of having a little insulation out front, but it seems to me that if closures are not needed, then I wouldn't imagine that the Commission would ever come down and recommend the closing of the facility. So what's there to hide? Why preclude the Commission from looking at an

important possibility and a legitimate valid option? It's an extraordinary game that we're playing here. Everybody should be aware of it.

I'd like to meet with the veterans' organizations personally because I think they're making a mistake here by using their muscle to suggest that under no circumstances, if this Commission finds anything which should be closed, should be closed. I think that's a mistake, and I think we should try to address it on a 1 to 1 basis. I'd be happy to meet with them individually, collectively, or whatever because we're not trying to unwind this health-care system, we're trying to increase the efficiency.

I think I've examined that point enough, Mr. Chairman, and I thank Mr. Principi.

I'd welcome any of the veterans groups that would like to pursue this because I think it's just in the Nation's interest and I'm very concerned with the potential backlash of the taxpayer who's saying, "What's going on here?"

Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much.

I thank you all very much for coming back to us today, and for your testimony.

The next panel, appearing on behalf of the Association of American Medical Colleges, includes Dr. David Korn, the Dean of the Stanford University School of Medicine, in California. I want to say to David that I'm particularly delighted that you're with us this morning.

Also with us is Dr. William Butler, the President of Baylor Medical College in Texas, who's appearing in his capacity as Chairman of SMAG, the VA's Special Medical Advisory Group.

I look forward to hearing each of your ideas and the positions of two organizations on which we often rely for sound advice.

Dr. Korn, would you please proceed, and again welcome to you.

STATEMENT OF DR. DAVID KORN, VICE PRESIDENT AND DEAN, STANFORD UNIVERSITY SCHOOL OF MEDICINE, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. KORN. Good morning, Senator and members of the Committee. I'm David Korn, Vice President and Dean of the Stanford University School of Medicine. On behalf of the Association of American Medical Colleges, I appreciate the opportunity to be here this morning.

The Association of American Medical Colleges supports proposals to review VA's current structure with the aim of improving the system's coherence. We look forward to working with Congress, the Administration, veterans' service organizations, and other interested parties toward this mutual goal. I am pleased that the Secretary has asked for input from a variety of sources, including medical educators, and that the deliberations of the Commission will be conducted openly.

We agree with the Secretary that the VA's primary focus must be on the best way to meet veterans' health care needs. I am pleased that the Secretary specifically asked the Commission to consider, "Changes which may occur in medical education and the

possible impact of these and other changes on VA-academic affiliations," among the points for review.

Affiliations are symbiotic arrangements that I believe benefit both the VA and medical schools. They improve immeasurably the quality of care by enabling the recruitment and retention of talented professionals and by creating a dynamic environment. Both partners in the affiliation share a common goal, since a quality health-care environment is not only good for veterans, but is essential for medical education.

Affiliations evolve as the health-care system and the corresponding needs of veterans and medical education change. Let me mention two distinct factors because of their relevance to the VHS&RA—namely, the practice of medicine has shifted toward ambulatory settings and the population is aging.

Medical schools are attempting to adapt their programs to these developments, for example, with the kind of specialized treatment and research programs that we have at the Palo Alto facility in geriatric research, education, and clinical care called "GRECC." These programs are equally important to veterans and to our training programs.

Affiliations can also be very effective mechanisms for facilitating the development of VA regional health-care networks. We, for example,have been affiliated with the Palo Alto facility since the early 1960s. In the past year we entered into a new affiliation with the Livermore VA Medical Center. This new affiliation will allow us to solidify a nascent relationship between Livermore and the tertiary care programs of the Palo Alto center.

In other words, I suggest that affiliations can be used as a foundation for efficient "hub-and-spoke" networks between VA facilities of differing complexity that will allow the delivery of convenient and cost-effective care to veterans in a broad geographic area.

I hope the Commission will consider the resource problems facing the VA. Recurring funding shortfalls have a very negative impact on patient care. The Commission should also review whether the VA resource allocation methodology properly recognizes resource intensity in medical centers that treat higher acuity patients, or whether it adequately responds to resource usage in the ambulatory health-care environment.

The Association of American Medical Colleges pledges to review, without bias, the determinations of the Commission. Our support will not be deterred by recommendations that may adversely affect some of our members. I think the Association of American Medical Colleges has demonstrated good faith in this regard, although, like Members of Congress whose districts may be affected, some individual institutions may oppose certain changes.

I remind the Committee of the results of the VA's 1986 internal review of the cardiac surgery program as a good example of how difficult this process can be. Again we plan to work with our constituents, with the VA Central Office, with the Congress, and veterans' service organizations to help to resolve difficult decisions.

Our ability to participate, cooperate, and support would be enhanced if the academic community were represented on the Commission. I think we would add an important and unique perspec-

tive, and, in particular, to address adequately the Secretary's point regarding affiliations.

I understand that the Secretary has emphasized that he does not intend to dismantle the VA, but rather to do some rearranging. I believe the Secretary should be equally receptive to recommendations that might require increased resources to improve the system through realignment and enhancement.

Again, I very much thank you for the opportunity to be here to share my views with you, and I shall be happy to answer questions.

[The prepared statement of the American Medical Colleges appears on p. 127.]

Chairman CRANSTON. Thank you very, very much.

Dr. Butler.

STATEMENT OF DR. WILLIAM T. BUTLER, CHAIRMAN, SPECIAL MEDICAL ADVISORY GROUP, DEPARTMENT OF VETERANS AFFAIRS

Dr. BUTLER. Thank you.

Mr. Chairman, and members of the Committee, let me first express my appreciation for rearranging the schedule this morning. We are all under a pressure of time, as I know you are too.

My name is Dr. William T. Butler, President of Baylor College of Medicine in Houston, TX. For the past 8 years, I have served on the Special Medical Advisory Group, and for the past 5 years I have been privileged to be the Chairman. The Special Medical Advisory Group was created by Congress in 1946 to advise the Congress, the Secretary, and the Chief Medical Director on the medical affairs of veterans.

This group brings a unique perspective because the broad spectrum of the experience of the members representing all segments of American medicine, including former Congressman Paul Rogers. For your interest, I have appended a list of the Committee members to my written testimony.

Since none of the members are employees of the VA, they bring additional objectivity to the Committee's deliberations. Wearing another hat, I have been the Cochairman of the Dean's Committee of the Houston Veterans Affairs Medical Center for 12 years, and have been a medical consultant to the hospital for over 24 years.

I have submitted a written copy of my testimony and will simply highlight several points.

I support a thorough review of the Veterans Affairs system such as that proposed by the Secretary. The Veterans Affairs system is clearly a national resource and holds a respected and unique position in the pluralistic health-care effort of our country.

The Special Medical Advisory Group recently transmitted the following resolution to the Congress. "The Special Medical Advisory Group reiterates and reconfirms its whole-hearted endorsement of the existing Veterans Affairs system; a federally financed system of care dedicated to America's veterans. The Veterans Affairs system is a prudent, stable, dependable, national resource. It provides health care for veterans who have served their country. It augments American medicine through its continuing achievements in clinical, education, and research endeavors."

The role of the Veterans Affairs health-care system has undergone many changes over the years, but I'm always mindful of the quote by Abraham Lincoln that is on the outside of the VA Central Office, "To care for him who shall have borne the battle and for his widow and his orphan."

That statement is central to the existence of the VA medical care system. But within that philosophical context the VA also is becoming, to an increasing extent, a care system for medically indigent veterans, as well as those with service-connected problems.

We are all aware of the stress that is now on the indigent health-care systems within our Nation's communities. These institutions are already overburdened and underfinanced. What would happen to our Nation's veterans if their care were no longer provided by the VA? It is clear that our local communities simply do not have the resources to provide the standard of care which our veterans deserve and to which they have been accustomed.

High standards of care also are the goal of our Nation's medical schools affiliated with the VA, as Dr. Korn has just testified. Because of these affiliations, VA medical centers attract young, vibrant physicians who want to practice medicine in an environment where medical knowledge is at the leading edge of discovery.

Recently, however, those of us on the Special Medical Advisory Group have become increasingly concerned about the gradual erosion of financial support for the programs of the VA. We are now hearing of instances where the quality of this care may be compromised by inadequate staffing and resources. I believe the system's ability to maintain quality has now reached its limits.

On top of the diminished resources, the VA is also challenged by the changing face of medicine. Despite staffing reductions the VA must cope with, for example, the aging population, the AIDS crisis, and the changing demographics of veterans.

I would point out that the proposed VA Commission may well find that the indicated adjustments to the VA health-care system require a greater, rather than a lesser, total commitment of national resources, but I am also fully supportive of instituting cost-saving measures when clearly indicated. The Special Medical Advisory Group also supported the reductions in cardiac surgery programs at selected hospitals that Dr. Korn alluded to.

Whether the Commission's findings indicate a need for expansion or reduction in facilities, or for more cooperative arrangements with existing health providers in both the public and private sectors, I think the Commission is central to the whole issue of the integrity of the VA system.

I applaud Secretary Derwinski for moving quickly to assure that VA medical facilities during the foreseeable future provide the best possible care.

Thank you for allowing me to testify, and I too will be glad to answer any questions.

[The prepared statement of Dr. Butler appears on p. 129.]

Chairman CRANSTON. Thank you very, very much. I appreciate the testimony both of you have given and your help.

I want to congratulate the Association of American Medical Colleges and Dr. Korn for your very enlightened statement that "our support for the Commission will not be deterred by the presence of

certain recommendations that will affect some of our individual members."

Dr. Korn, although you're here today representing the Association of American Medical Colleges, you're the Dean of the Stanford University School of Medicine. Likewise, Dr. Butler, while you're here representing the VA Special Medical Advisory Group, you are the President of the Baylor College of Medicine. In these roles, I want to ask how you would deal with the following, not unexpected situation.

Suppose that after extensive review of the medical care needs of a given locality, the Commission wants to recommend to change a tertiary care hospital into a skilled nursing facility, yet you, as Dean, have been relying on that hospital to provide training and service experience for some high tech subspecialties, as well as for the full range of sophisticated acute care services. How would each of you as Dean approach such a situation? What I'd like to ask you to do is to respond very briefly now, and if you wish, amplify your response in writing for the record.

May I start with you, Dr. Korn?

Dr. KORN. Yes, sir.

I find it hard to know how to answer that question, Senator, because if such a facility were not in fact serving a need reflected by a patient population and by a range of services that were being used adequately in terms of their volume, it wouldn't be a very good educational center. In other words, a half empty, or a third empty, or a 10 percent full hospital would not be an adequate place for training, so it seems to be that were either Bill or I in that sort of a situation, we would have been—long before now—looking for alternative ways for finding the educational and training experiences that that facility was no longer providing.

If the facility is meeting that full range of services, and at a high level of quality, then I have a problem understanding why the Commission, or any commission, would suggest closing it.

I respect your question, and I'm intrigued by how difficult it is, but I don't quite know how to answer it in any other way.

Chairman CRANSTON. Well, think some more and send me a letter. [Laughter.]

Thank you very much.

Dr. Butler.

Dr. BUTLER. In many ways I agree with Dr. Korn. If there is a tertiary care hospital which is fully functional, it is hard to believe that that hospital would be converted, for example, to a nursing facility, because the needs of the veterans in that community in supporting a tertiary care hospital would have to be met by some alternative mechanism.

If one assumes that one wants to maintain those veterans in the veterans care system, then they will require the maintenance of a tertiary care hospital to meet those needs. Therefore, it would be very hard for me to see a major tertiary care hospital to wholly change its mission. I can see modifications of hospitals where there are empty beds. For example, if 20 percent of a hospital's beds are not occupied, then they could be utilized for purposes that were not central to the mission of that hospital. I believe that's the kind of recommendation that might be more realistically made.

Mr. STEINBERG. Drs. Korn and Butler, let me suggest that you consider one possibility as a context for your written response.

Secretary Derwinski has many times—and I'm sure you've heard him, I'm sure Dr. Butler has—referred to the situation in Chicago where you have a number of facilities located geographically very close together—and said, "Does it make any sense for us to be having active surgical programs, for example, at each of those facilities?" I'm not aware, by the way, that at any of those facilities the surgical programs are undersubscribed, so my assumption is that they are operating at a relatively efficient level, but let us say that it is believed that by merging three or four surgical services into one surgical service—expanded, obviously—a more efficient and perhaps more effective level of care could be provided.

And let us say that there were two or three medical schools that were closely affiliated with the surgical beds in the facilities that would no longer have surgery. That's a situation, perhaps, that doesn't fit into Dr. Korn's first situation and would fit into his second situation.

The question for you to think about—and perhaps give us some guidance on—is how would you be likely to respond if that were your medical school, and you were dependent on those surgical beds for teaching surgery, and for your surgical residents?

Dr. BUTLER. I would respond by saying that I believe change will occur by evolution rather than revolution and that it is unlikely that there would be a total reduction of a surgery service in a hospital. As I understand the hospitals from the Secretary's testimony last week, they are about 6 miles from each other. That means that they each represent a geographic catchment area basis within that community as well. It is hard to operate any major hospital without a major surgery service because it is interlinked with all the other services that are rendered. If a patient is on the internal medicine service, he or she will need a surgical consultation for cases of abdominal pain. It is difficult to think that there would be no surgical service at that particular hospital.

But what I could conceive might happen would be that highly sophisticated, technological surgical procedures would be isolated to one or more of the institutions, thereby conserving resources of the other institutions.

Chairman CRANSTON. Thank you both for your responses. I look forward to hearing more from you on that subject.

Last week I asked Secretary Derwinski about the real and perceived problem of the Commission's staff being totally under the control of VA. What are your reactions to my concern? And specifically, if Secretary Derwinski asked you to serve as members of his Commission, which he said would be totally independent, would you feel comfortable with the structure and relationship to be—as it is now conceived with an executive director and all 30 staff, except for a writer—being current VA employees, and being already largely selected?

Dr. BUTLER. That is technically a difficult question, as you know. I have actually advised the Secretary that he be very concerned about the perception of the objectivity of the Committee, and that if the perception were that it was an internal group that was dictating the solutions and recommendations, it ought to be modified

to bring a degree of objectivity to it. If that means additional people from the outside, I would certainly support that.

Chairman CRANSTON. David, do you have any comment?

Dr. KORN. Senator, I agree with that. It seems to me—I've been thinking how this Commission will possibly accomplish its task on a fairly tight timeline which, as I understand it, has been charged by the Secretary. It's going to be very dependent upon the staff clearly, not only for amassing the data, but the way they're amassed, the way they're analyzed, and the way that they're presented. Nobody on the Commission is going to be able to spend each day of a year and a half personally collecting and analyzing and formatting data so that it does seem to me that the staff is going to be terribly important in what the Commission sees, how it sees it, what facts and interpretations get presented to it.

I think it would be healthy if they were not entirely an inside VA staff. Now how that could be done functionally and budgetarily, I don't pretend to know. I think that it would help it and give it credibility.

Chairman CRANSTON. I thank you both for your comments on that.

David, although this is not part of the Committee's agenda for today, I can't pass up the opportunity to ask for a status update on the conditions at your affiliated VA medical center, the Palo Alto VAMC. How are conditions there, in your opinion, and how is VA staff morale? What is the condition of the affiliation with Stanford, and what are your concerns about the overall situation at the VA medical center?

Dr. KORN. OK, thank you.

As you know, on October 17, the earth shook, and as one consequence the main medical surgical hospital in the Palo Alto VA Medical Center was condemned and is now empty. I'm very proud of the fact that the entire hospital was evacuated in 28 minutes and there wasn't a single casualty. I think that's really a quite remarkable achievement.

What saved our life, and I'm reminded of it by the gentleman behind me—Mr. Powell I think it is—was the fact that independently, a spinal cord injury center program, which Palo Alto had established a long time ago, had finally made it through funding for a doubling of its capacity from 30 beds to 60 beds. That center is headed by a distinguished physician who holds the Paralyzed Veterans of America endowed chair. My memory was triggered because he and I appeared at a midwinter meeting of the Board of Governors—I guess it is—of that organization to receive a large check about 2 years ago, I think, at the Mayflower Hotel.

In any event, the facility had just been constructed, it had not yet been activated, and therefore when the main medical surgical hospital had to be evacuated, quite fortuitously there was this structure available in which to put the patients. So what we've done is to take an expanded spinal cord injury center built for 30 veterans, and have packed into it the entire medical surgical hospital that is now evacuated.

Rooms that were developed for two paralyzed veterans—therefore slightly larger than an average two person room—are now

holding six beds, three by three, side by side. You really have to like your neighbor in that situation. [Laughter.]

There are no offices. The labs are in closets, basically. The hallways are packed.

I think that the staff morale had been sensational in the immediate aftermath, much as staff or people in general respond to crisis. But lately I'm beginning to sense a weariness and a bit of what I guess might be post-traumatic stress syndrome perhaps. I noticed even in the most recent Dean's Committee meeting, about 2½ weeks ago, that my veterans' service organization representative, who was always good for a positive comment, also expressed his concern that he was having increasing problems getting the volunteers to appear because they've been doing an awful lot of staff work resulting from the dislocation, moving of patients around, supplies, and everything else.

The urgent thing we need is a decision. We know that any reconstruction is going to take time and I'm very aware that it's going to be a budget problem, but the uncertainty is now the biggest negative and we do need a decision. I do hope it's a good positive decision on rebuilding that hospital.

Chairman CRANSTON. I thank you for that report. I thank you both for your testimony. I want to assure you, David, I'm doing what I can to help in that situation.

Dr. KORN. I'm very, very grateful to you, sir, and to the Committee because they've been my guides on this whole experience and I've learned a lot.

Chairman CRANSTON. Again, we thank you both very, very much for rearranging your schedules to be with us here again today and share you views with us.

Dr. BUTLER. Thank you, sir.

Chairman CRANSTON. The Committee will now hear from representatives from four veterans' service organizations: Dennis Cullinan, Assistant Director of the National Legislative Service of the Veterans of Foreign Wars; R. Jack Powell, Executive Director of the Paralyzed Veterans of America; Thomas Sherwood, Director of Health Policy and Planning of the Vietnam Veterans of America; and John Sommer, Director of the National Veterans Affairs and Rehabilitation Commission of the American Legion.

Dennis, would you please start off.

STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you, Mr. Chairman.

On behalf of our 2.2 million members, I'd like to thank you for this opportunity to present our views with respect to the Commission on the future structure of veterans health care. At the outset, I'd like to take this opportunity to extend a special thank you to you, and the other members of this Committee, for your contributions in the initial VA budget deliberations, and of course for the recommendation that an additional $1.3 billion be provided for the Department of Veterans Affairs over the President's request.

In your letter of invitation, you asked us to comment on three proposals, two of them pertaining to legislation which would provide for realignment and possible mission changes of VA health care within the Department of Veterans Affairs, and the Commission on the Future Structure of VA Health Care, which the Department has established administratively. Inasmuch as the VA has already established a Commission, the advancement of legislation to establish such a Commission is, in our opinion, unnecessary at this time. Therefore, we do not support the enactment of the two bills presented to us today.

Now I would like to address what we perceive to be the role of the VA's Commission and how it may impact on our Nation's veterans. The Veterans of Foreign Wars does support the concept for establishing this Commission. In fact, we have long argued that the VA health-care system should invest more time and energy in planning for the future.

On the other hand, we are deeply concerned that this Commission should be strongly oriented toward finding ways of providing veterans with the full continuum of care that is their due.

All too often in the past, when there was talk of reexamining the VA's mission, the reduction of services has been the hidden agenda. Experience has taught us to be very wary whenever the VA health-care system's mission is the topic of discussion on Capitol Hill. We have seen terms such as "mission realignment," "consolidation" and "management efficiencies" often really mean closing VA hospitals and generally reducing services to veterans.

Even so, we have seen that Secretary Derwinski may make quite a capable veteran's advocate, so we will not now oppose the formation of this VA health-care Commission.

Mr. Chairman, that concludes my remarks.

[The prepared statement of Mr. Cullinan appears on p. 131.]

Chairman CRANSTON. Thank you very, very much.

Mr. Powell.

STATEMENT OF R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. POWELL. Thank you, Mr. Chairman.

For many years, the Paralyzed Veterans of America has in fact called for a Mission Review Commission. Therefore, from one aspect, we're certainly glad to see that one is about to begin.

The problem that concerns us is from where do we begin. Before "Dominoes" worried about how it was going to deliver a food product, it decided what food product it was going to deliver. It decided pizzas. Certainly that's the difference between being able to use an automobile and requiring a truck. We don't believe that the VA has in fact decided who it's going to deliver care to, or what kind of care it's going to deliver to them. In fact, we noticed that there appears to be a great disagreement over where present reality is in the VA health-care system today.

We believe that the VA has been and in fact is continuing to reorganize the health-care system through a variety of actions or inactions, and in each case the result has been to reduce the level of services for eligible veterans. Because of funding shortfalls in the

past several years, category B and C eligible veterans have been completely denied access to the system and written off.

Today we're in the process of splitting up category A eligible veterans, and determining which of those are A pluses and which of those are A minuses.

Most of these things appear to be driven by a dollar shortfall, and yet in a recent letter written to Representative Bob Traxler, in the House of Representatives, the Secretary states that the VA has in fiscal year 1990 $72 million more than we estimated we would need. Then we're concerned because we read an IG report on Portland, OR, which says the review validated the fact that a significant shortfall of resources existed in the medical center. This shortfall had caused the medical center to: (1) divert veterans to community hospitals, (2) place a limit of 80 percent on the acute care bed occupancy rates to assure safe patient care and prevent the staff from being severely overworked, (3) institute a limited hiring freeze, (4) reduce outpatient visits, (5) reduce the number of non-service-connected veterans who are receiving kidney dialysis, and (6) close one 39 bed ward and not open another 40 bed ward.

At the same time that we have that example in Portland, OR, an IG report that indicates a deficit of more than $10 million, we have a report of a deficit of greater than $12 million at the Minneapolis VA Medical Center. This is true in smaller hospitals as well. In Lincoln, NE, they've reduced staff, restricted new hires, and funding levels are currently $346,000 below requested levels. Medical supply inventories will be depleted by the end of the fiscal year.

In Columbia, MO, headlines in the newspaper show the turning away of veterans. It says that they are $2.2 million in debt already. In West Roxbury, MA, 6 months into this fiscal year they already have a deficit in just the pharmacy account alone of $700,000—that's 6 months into the year. And yet we simultaneously hear that the VA has $72 million more than it estimated it would need for fiscal year 1990.

That makes us question what is the basis of the estimate of the VA's need? Is it to serve those veterans who today are eligible under title 38, and entitled under title 38, or is that $72 million more because we have a preconceived, as yet undisclosed, redefinition of who in fact is eligible and who is entitled for veterans health care?

We have in fact supported the idea of a Mission Review Commission for a number of years, but in fact we would like to associate ourselves with the testimony submitted in writing of Dr. Donald Custis to this body, in which he, as a staunch proponent of a Mission Review Commission, indicates that at this point in time the appointment of such a Commission may be critically premature because we have not yet decided whether it is pizza we're going to deliver or health care to veterans, and what veterans we're going to deliver it to.

Continuously used in the VA's material discussing this are "eligible" veterans. Title 38 clearly establishes some entitlement, and it clearly establishes eligibility. If we in fact intend to comply with that eligibility, then why don't we just simply say that? Why do we use the term "eligible" veterans, unless we have some supposition that we're going to change that?

A point in fact, I refer to the fiscal year 1990 budget presentation briefing given by the Department of Veterans Affairs and question this Commission could proceed without first making the determination of who was eligible and what they were eligible for? And the Assistant Secretary for Finance informed that, in fact, this was going to be the first task of the members of this Commission.

We believe that eligibility and entitlement ought to be established by the House and Senate of the United States and not by a group of employees appointed by a political appointee. For many years that has served veterans well, and I'll conclude right there, Senator.

[The prepared statement of Mr. Powell appears on p. 134.]

Chairman CRANSTON. Thank you very much, and thank you for responding to the bell, too. [Laughter.]

Mr. POWELL. Bells are something that always get me, Mr. Chairman.

Chairman CRANSTON. Next, Mr. Sherwood.

STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. SHERWOOD. Thank you very much, Mr. Chairman, for the opportunity to appear here.

Vietnam Veterans of America, Inc. supports the proposed initiatives to provide realignment and major mission changes, as necessary, of medical facilities in the Department of Veterans Affairs.

The Commission offers all concerned an opportunity to know what is truly required to care for veterans in medical facilities in terms of required commitments, resources, programs, and most of all, costs.

The fact is, leadership in certain veterans' service organizations, Congress, and the Veterans' Administration, in their sincere attempt to protect what resources were available to the VA healthcare system, may have over the years inadvertently shielded the public from coming to grips with the true cost of veterans healthcare delivery in this country. In turn, the veteran may have been ultimately "short changed" by the process, and the public denied the opportunity to either take responsibility for the American commitment to its veterans or to reassess that commitment.

The Commission offers the opportunity to do the important assessments so that responsibility can be taken.

We strongly recommend that as the missions are defined and redefined at the medical center level, the Commission takes into consideration the views of both staff and veteran patients.

We strongly support the requirement that a separate budget be established for the Commission and its operations.

We strongly request that the Commission not be used as a device to either justify savings, or as a rationale to facilitate the Department contributing toward budget deficit reduction.

We believe veterans want to do their share in contributing to the economic strength of this country while at the same time this country wants to remember the contributions veterans have made to its well-being.

We strongly request that the Commission not be used as a device to either continue a process of centralizing operational control of the agency to Department of Veterans Affairs Central Office at the expense of the field, nor as a device to indirectly cope with issues of potential micromanagement by, or within, either congressional, Federal, or advocacy institutions.

Finally, we are hopeful that the Commission will be seen and used as an opportunity to improve the Department of Veterans Affairs health-care system which by many accounts, is in serious trouble.

Thank you very much for the opportunity to present our views.

[The prepared statement of Mr. Sherwood appears on p. 136.]

Chairman CRANSTON. Thank you very much.

Mr. Sommer.

STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. SOMMER. Thank you, Mr. Chairman.

The American Legion appreciates the opportunity to offer comment on the proposals under consideration today on the future structure of veterans health care.

We've recently witnessed the results of the VA medical care system falling victim to funding shortfalls resulting from a number of factors. Additionally the average age of the veteran population continues to increase, and with advancing age, veterans require more expensive and a larger number of health-care services.

However, there are also other problems that need to be reviewed and remedied in the system to include the need for additional inpatient post-traumatic stress disorder treatment units in VA facilities. We believe that VA certainly needs to properly assess the medical needs of veterans over the next several decades and be prepared to provide the appropriate mix of services to accommodate those needs. However, we believe the objectives of such a Commission can be appropriately met through the administrative creation of an advisory panel.

We understand that the Advisory Commission proposed by Secretary Derwinski will examine all aspects of the Veterans Health Services and Research Administration. The American Legion has been encouraged that the Secretary has stated and restated that no medical centers will be closed as a result of this study.

We're totally supportive of all Commission meetings being preannounced and being open to the public. Our major objection to the initial proposal is related to the fact that the Commission would have operated in secret.

The American Legion will monitor the work of the Commission and exercise our prerogative to comment on any aspect of the Commission's interim or final reports.

It's extremely important that a separate budget be established for the operation of this Commission rather than siphoning funds from already strained medical care accounts. The Secretary's philosophy of "equally good access to equally good care" should apply to all eligible veterans. We have found that some veterans who are

now being denied care based on means test criteria are unable to obtain alternative treatment. Additionally, many deserving veterans cannot obtain health insurance even though VA guidelines say that they can afford private health care. We are currently conducting a study to determine how these factors are impacting a sample of these veterans over a period of time.

The American Legion offers its cooperation in the Advisory Commission's assessment of the anticipated medical needs of veterans, both now and in the future. And, as previously stated, we will exercise our prerogative to comment or criticize its proposals where necessary.

Mr. Chairman, that concludes our summary.

[The prepared statement of Mr. Sommer appears on p. 138.]

Chairman CRANSTON. Thank you very much. I appreciate the testimony from the four of you and from the organizations you represent.

I don't mean to gloss over the distinctions that have been made by each of your organizations, some of which I will address in questions, but it seems your positions can be summarized by saying that there is general intellectual support for an overall look at VA's strengths and weaknesses, there's a recognition of the fact that there is room for improvement, and there's recognition of the need to explore the future characteristics and needs of veterans and to develop better ways to serve them.

However, this support is tempered by some rather strong reservations, that you apparently have, that seem to be based largely on uncertainty about the Commission, about the expertise and philosophy of its members—now unknown—about what constraints they may feel in making recommendations, and about what questions they may ask.

Is that a fair summary? Does anybody differ with that view?

Would your concerns be reduced at all if at least one member of the Commission came from a list of recommendations developed by concerned veterans' service organizations?

Mr. SOMMER. Mr. Chairman, speaking for The American Legion, I know that we have been contacted by the Secretary for a recommendation, as I believe the other organizations have, and we certainly want to take that opportunity to provide a recommendation to the Secretary relative to member of the Commission.

Mr. POWELL. Mr. Chairman, speaking for the Paralyzed Veterans of America, I had the opportunity last week to hear you question the Secretary about veterans' organizations representation. Perhaps I misheard—I didn't wait for the opportunity to read the transcript—but I heard the Secretary consistently come back and say that there must be somebody with medical expertise and background in the veterans community rather than consumers. It seems to me that veterans are 100 percent of the consumers of the VA health-care system, and that they ought to be more than 2 percent of the Commission.

Chairman CRANSTON. Any other comments?

Mr. CULLINAN. Mr. Chairman, on behalf of the Veterans of Foreign Wars, we're anxious to play a role, primarily in an oversight capacity of this Commission. However, I must say that I don't think we'll be any less worried until the full nature of this Com-

mission is revealed, and the kinds of recommendations that they're going to make are made known to us.

Chairman CRANSTON. Any other comments?

Mr. SHERWOOD. I would concur that, particularly with respect to the submitting the names on request.

Chairman CRANSTON. The Secretary said that he would welcome a list of joint recommendations of such a person. Would each of your organizations be willing to participate in an effort to develop one?

Mr. CULLINAN. Yes, sir.

Mr. POWELL. Yes, sir.

Mr. SHERWOOD. Yes, sir.

Mr. SOMMER. Yes, sir.

Chairman CRANSTON. A joint recommendation?

Good.

I'd appreciate it if you would share with the Committee a copy of what you submit. I should think you should just go ahead and do it.

Is that OK?

Are you concerned about the effects on the independence of the Commission of having all of its staff be VA employees?

Mr. POWELL. Mr. Chairman, I might point out that the subject of the Commission—and I'm trying to do this in the most tactful way possible—the subject of the Commission is to come up in 18 months with a report on a revision and restructuring of the entire VA health-care system, and yet we know that the VA has, for 14 years, been laboring and trying to produce staffing guidelines simply for nurses in the health care system. We wonder whether the staff that can't do that, can in fact restructure the entire system in 18 months.

Mr. SHERWOOD. Myself, I do make a distinction between the staff support which is obviously very necessary, as was previously outlined. Clearly the Commission cannot do the research and all the other staffing operations that are associated with that function.

Second, I have no reason to believe that the VA staff has any less integrity than anyone else in terms of carrying out that function as long as the distinction is clear between Commission and staff, and their roles are clearly defined.

Mr. CULLINAN. Mr. Chairman, the Veterans of Foreign Wars would agree that a VA staff support is essential to the successful operation of this Commission. However, we also believe that a distinction needs to be drawn between the facts that are provided and then the eventual decisions or policies which are implemented or provided by the Commission itself.

Mr. SOMMER. As for The American Legion, the question of staffing, and whether it should be outside VA, never entered into our consideration, presuming that the Commission is going to be making the decisions that are set forth in the findings of the reports.

Chairman CRANSTON. Several of you have mentioned the desirability of making inpatient and outpatient entitlement the same. Would you support achieving that result by reducing the number of individuals so entitled, but then entitling them to a full spectrum of comprehensive care from outpatient to nursing home?

Mr. CULLINAN. Mr. Chairman, the Veterans of Foreign Wars would not support reducing the number of eligibles, in other words redefining eligibility criteria to preclude veterans who are now eligible for VA health care.

However, we view providing outpatient care as being not only in keeping with providing veterans with a full continuum of health care, but also eventually cost-effective as well. In a way similar to how HMOs now provide for medical examinations and don't require that a person wait until he's sick to come in for health care. We believe that providing outpatient care will allow VA to prevent serious illness in veterans, and prove to be cost-effective in the long run as well as proper.

Mr. POWELL. Mr. Chairman, perhaps a couple of years ago, on behalf of Paralyzed Veterans of America, we might have done that. In fact, if we recall back a few years ago, it was virtually every veterans' organization in this country that sat down and agreed to the establishment of a means test and categories A, B, and C. I think that the situation has changed, and those who encouraged us not to agree to that today have a greater credence.

Because we agreed to less than 5 years ago to the categorization of As, Bs, and Cs, within 2 years of that time Bs and Cs have been completely written off, and once again we're asked to look at category A as a subdivision. The question that would probably bear a lot of sway with the individual veterans of this country would be, when does it stop?

If we agree now to give up some veterans in return for an expanded entitlement for others, next year will we be cutting that number again?

Mr. SOMMER. Mr. Chairman, I'd like to remind my colleague that The American Legion was the only——

[Laughter.]

Mr. SOMMER [continuing]. Veterans' organization that opposed the establishment of the means test and the categorizing of veterans, and its for that reason that we're certainly upset about the fact that category B and C veterans are being denied care.

As far as we're concerned, we feel that the means test should be totally done away with.

Mr. SHERWOOD. I would only comment that the whole idea of the means test and the consequences that have come about with respect to the differentiation between categories A, B, and C is primarily driven by resource limitations and decisions relative to the lack of dollars in the system, rather than having been driven by real needs of veterans. I think that we need to address the initial issue first, and understand that the mess that we're in relative to eligibility is being driven by the wrong things, namely budget balancing over veterans needs.

Mr. POWELL. Mr. Chairman, if you'd indulge me for 1 minute——

Chairman CRANSTON. Certainly.

Mr. POWELL. Let me point out to you that today it is possible for a category B veteran to receive outpatient care that a category A veteran is being denied under guidance of the VA. That's a fact today.

Chairman CRANSTON. I thank you for your comments.

I regret that I'm going to have to leave at this stage to go to another committee.

As you know, this is the second round of this hearing, and my schedule couldn't allocate the whole morning to it.

I thank you for your testimony up to this point. Counsel Jon Steinberg will carry on with questions that I would have asked were I able to stay, and I apologize to the witnesses in the final panel that I will not be here for your testimony. But I will know what you have said, and will take your testimony into account.

I thank everybody present very much, and I now turn the gavel over to Jon Steinberg.

Mr. STEINBERG. Thank you very much.

Jack, could you clarify for us, is the Paralyzed Veterans of America opposed to the Commission that Secretary Derwinski proposes to establish administratively?

Mr. POWELL. We're opposed to the idea of the launching of a Commission without first establishing clear entitlement, who's entitled for what, and how are they entitled to receive it.

Mr. STEINBERG. Since such entitlement, in your opinion, is not provided under current law, one would have to assume that under current law you are opposed to the establishment of the Commission?

Mr. POWELL. That's correct.

Mr. STEINBERG. Do any of the other panelists and their organizations share that position?

John shakes his head, no—Dennis, no—Thomas——

Jack, what is it about the Secretary's proposals for the Commission that lead you to conclude that the Commission is designed "to provide the initial basis" to—in David Stockman's words—"shrink the system slowly over time?"

Mr. POWELL. I don't think that one can take just a single action and make a determination based on that single action alone. I think one has to take the entire environment of actions being taken, and then say—predicated on all of these actions taking place—"Do you believe this one statement?" Last night the House of Representatives passed a supplemental for fiscal year 1990 of $50 million. The Senate has yet to act. We can account for, among six hospitals, over $27 million of shortfall in fiscal year 1990, just in six VA hospitals.

The Senator from Alaska talked last week about a fair, open, honest, objective assessment. Is it an honest, objective assessment if you start out from the standpoint that you have a $72 million surplus while your hospitals are indicating millions of dollars of shortfall? We're talking about the elephant as seen by a blind man here. The kinds of things that can be gained in the restructuring of the VA health-care system—a greater shift on outpatient care and that type of thing—can only come about if in fact there is an entitlement to outpatient care, and that is the law, and you're going to act on that law.

So we would question this about the Commission. Is the Commission going to base its perception on a structure to deliver services based on the law as it is today—on hospital utilization and health-care utilization patterns as they are today, as they were 2 years ago—totally different from today—or as they are going to be 2

years from now in the future while the Secretary's other Commission reviewing veterans benefits and entitlement are rendering their report?

Mr. STEINBERG. I think we can answer that last question, of the several that you posed.

According to Secretary Derwinski's testimony last week, the Commission would assume, for its deliberations, the continuation of current law, and would not be asked to make recommendations with respect to modifications in current law. That was his testimony last week.

Mr. POWELL. I heard that, but I also heard that in no way were we going to bias or commit this Commission, and yet I've heard repeatedly from both sides of this table, that rural hospitals are not going to be touched, it's going to be urban hospitals where we've got three or more VA facilities. This organization participated in a very lengthy study that was released in 1987 of the 1986 health care data looking exactly at one of the classic examples that's been offered before this Committee and that's Chicago—the three VA hospitals—and what would in fact happen to veterans if you attempted to consolidate various services.

If you're going to do a Mission Review Commission and say, "Whatever this Commission comes up with, whether more money or less, more hospitals or fewer, more nursing homes or fewer, we will report that out, and that's in fact what will proceed," then Paralyzed Veterans of America would certainly endorse that, whatever the outcome may be.

But if you're going to start out and say that $12.3 billion is $72 million more than we need for health care and we're going to figure out how to work it out for less than that, then we're opposed to that.

Mr. STEINBERG. I don't believe that there's anything in the Secretary's testimony that suggests that they were going to suggest any kind of limitation of resources to either $12.3 billion or any particular figure.

Mr. POWELL. I agree.

Mr. STEINBERG. Jack, just to clarify one additional item. In your prepared testimony, you referred to the Commission proposed in S. 1398 as Senator Cranston's Commission. Just to be clear, his introduction of that legislation along with Senator Murkowski was done at the request of the Administration, as a courtesy to the Administration, and is not a legislative proposal that he has put forward. That is the case, for the record, with respect to every legislative proposal that he introduces on behalf of the Administration which carries the label "by request," and he just wanted to make that clear.

Mr. POWELL. I understand that, and I apologize in attempting to shorten our testimony——

[Laughter.]

Mr. POWELL [continuing]. Having perhaps given that erroneous impression.

Mr. STEINBERG. Thank you very much.

Dennis, on page 4 of your statement, you call for there to be "the provision of specific appropriation support for any new entitlement to VA health care that Congress establishes." Does that mean that

the Veterans of Foreign Wars would propose that in creating any entitlements, Congress should make them contingent on a certain amount being appropriated before the entitlement would go into effect?

Mr. CULLINAN. We believe that when the need for a new entitlement is discerned, that when it is created, the appropriation dollars should be provided. In the case of VA, we don't think the entitlement should be predicated on the availability of dollars, we believe that when the need is discerned, and when it is provided, the dollars should ensue out of the Congress.

Mr. STEINBERG. The predicate of the question is that the authorizing committee cannot appropriate the dollars. I think virtually all of you have in this testimony, or in your legislative presentations, urged expansion of the outpatient entitlement. There is currently an outpatient entitlement. I think its overlooked sometimes that there is—although not the same as category A for inpatient—an outpatient entitlement now.

But virtually all of you urge the expansion of that. All the authorizing committee can do is to change the law in title 38. It cannot appropriate the funds. But what the authorizing committee could do in the context of doing that is to say, "This expanded entitlement shall take effect only if a given amount of money"—whatever it is best estimated that entitlement would entail in additional expenditures—"is made available" and from thereafter it would stay in effect.

It would not be on and off, on and off, but triggered once. That would then shift the focus very plainly and clearly, and the focus of your efforts, to the appropriations process. The authorizing committee and the Congress would have said, "We want that entitlement," but it has to be conditioned on the funds being there, and that would then put the burden on the Appropriations Committee to provide those funds. That's the predicate of this question.

Mr. CULLINAN. Jonathan, that's something that we'll have to mull over, for one thing. The only problem that comes to mind immediately is that if Appropriations doesn't care to go along, they could effectively block the proposals of the authorizing committee, the Veterans' Affairs Committee. We could see a situation arising where Veterans Affairs makes a recommendation, in fact enacts something into law, and Appropriations blocks it.

Mr. STEINBERG. That has more or less arisen already in the sense that each of your organizations has pointed out from time to time that there are category A veterans who are not getting hospital care now upon application, even though the authorizing law entitles them.

I'm sure that you also may be able to submit examples in the outpatient area where the entitlement is less, but there still is an entitlement where a 30 percent or 40 percent service-connected veteran who would be entitled to outpatient care under existing law is not getting it. That in essence is going on because of resource limitations. So the situation that you present is in a less direct way going on right now.

Mr. POWELL. It's more glaring than that, Mr. Steinberg. There are instances of 20 percent service-connected veterans not being

able to get outpatient care from a VA hospital which is in fact providing outpatient care to civilians.

Mr. STEINBERG. Well that's——

Mr. POWELL. Forget the veteran status.

Mr. STEINBERG. That is not in accordance with the priority system for outpatient care, but it is correct that those veterans are not entitled to outpatient care. There is a priority situation for outpatient care which should preclude the situation you describe from happening.

Mr. POWELL. That was a result of the sharing agreement established by this Committee's compromise 2 years ago, which is now being carried out in the VA system, as I pointed out in my testimony I hope, was clear.

As a result of that situation, and the guidance now being disseminated by VHS&RA to the field, it is possible for a service-connected veteran—category A but who's less than 30 percent—to be denied outpatient care at the time that a category B veteran—on the basis of being category B—can get the outpatient care because the category B is held to an economics means test that is substantially higher than the economics means test for pension, aid, and attendance.

But simultaneously beyond this point, is that between the B who may get the care and the A who's not getting the care, comes along now, as a result of our sharing agreements, a civilian with no relationship to military experience, who do receiving care.

Mr. STEINBERG. I may be incorrect, but I believe that under section 612(i), and the priorities that are established there for outpatient care, that sharing-arrangement veteran would have under law a lower priority than any service-connected veteran for outpatient care. I'm not saying that what you've said doesn't happen. I'm just saying that it's not in accordance with the statutory scheme that Congress established.

With respect to your category B example, were you suggesting that the category B veteran was eligible for aid and attendance?

Mr. POWELL. I'm saying that if you go strictly by the guidance that's being put out today, you could care for a category B veteran on outpatient and deny a category A veteran who does not meet the income test for aid and attendance pension, less than 30 percent.

Mr. STEINBERG. As I understand it, that also would not be in accordance with the priorities in section 612(i).

Mr. POWELL. We understand that many things are not in accordance with the priorities of section 612(i).

Mr. STEINBERG. That is the law just as creating this sort of category A outpatient entitlement that each of you proposes would be the law if Congress enacted it. I think it demonstrates that sometimes changing the law alone does not accomplish the result sought by changing the law, and Dennis, of course, pointed that out initially in his testimony, as did others of you, that if the funds aren't provided to match the entitlement, it obviously can't be fully complied with.

Mr. POWELL. Jonathan, I think that's exactly our concern here, what you have put your finger on, the difference between the words that are the letter of the law and the spirit that carries

those out. That perhaps is our concern about the Mission Review Commission as well.

Mr. STEINBERG. One last question and then I will see whether the Minority Staff Director, Alan Ptak, has any questions he wants to propose.

Tom, on page 4 of your statement you note that, the "Department of Veterans Affairs should not be expected to absorb the cost for the Commission." If there has to be an offset, however, where do you believe the approximately $4 million should come from in fiscal year 1990 and fiscal year 1991 for the Commission?

Mr. SHERWOOD. Perhaps from the scaling down of the military. [Laughter.]

There is a principle involved.

Mr. STEINBERG. It should not come from within VA, is your approach?

Mr. SHERWOOD. I think not. Certainly not from DVA Medical Appropriations. I think that that Commission in terms of what it can accomplish and the importance that it has for veterans allows for appropriations coming from other more healthy financial systems.

As one thinks of a trillion dollar plus budget, I should hope that we would be able to find $4 million somewhere.

Mr. STEINBERG. Would any of you have any problem in supporting Senator Cranston's proposal that funding should come from third-party reimbursement collections that VA makes, which at this point, as you know, return to the treasury and not to VA?

Mr. SHERWOOD. I have no problem with that.

Mr. SOMMER. That would certainly be far better than siphoning the money out of the medical care accounts which, as mentioned in our testimony, are already strained.

Mr. STEINBERG. Or minor construction, I presume, which is the route that the House has taken.

Dennis.

Mr. CULLINAN. Mr. Steinberg, the Veterans of Foreign Wars would not have any objection as long as OMB didn't turn around and take the money out of the appropriation request. I know that has come up with other pieces of legislation.

Mr. STEINBERG. They'd have to submit a budget amendment to do that now, since the budget request is here now for fiscal year 1991, and we already have an appropriation for fiscal year 1990. So this is a one-time kind of cost.

Mr. CULLINAN. A one-time kind. I was thinking down the road that there would suddenly be this mechanism for OMB to pluck funds.

Mr. STEINBERG. Yes, but this is supposed to terminate in the summer or fall of 1991.

Mr. CULLINAN. No objection.

Mr. POWELL. I think we ought to take it out of major construction rather than minor construction.

Mr. STEINBERG. Since that is a big problem because of the outlay rate, I'm not sure that you're totally serious in proposing that.

The outlay rate is only about 6 percent for major construction, so in order to achieve $4 million you'd have to take an enormous amount of BA in order to get the outlay for the $4 million.

Mr. POWELL. There is this question. If, for the next year and a half, you were involved in a major review of the health-care system, and what ought to happen, should you in fact be building new hospitals? I just came from Salem, VA last weekend. One of the issues there is while the new construction is going up, they're padlocking the doors on existing construction because they can't afford employees to be in there and staff the beds. They're using Red Cross volunteers to feed patients in the health-care setting.

That's amazing to me. If we're really serious about this, then why take it from minor? Minor construction is what you need simply to maintain what you presently have. That's my understanding of what minor construction is. You know better than I do about all that.

Why would we be building new hospitals? Let's take it out of the new ones.

Mr. STEINBERG. We're not building very many new hospitals, by and large, we're——

Mr. POWELL. You don't need to build many at $140 million a pot.

Mr. STEINBERG. Or $240 million a pot.

Mr. POWELL. That's true.

Mr. STEINBERG. But major construction is very often renovating, or providing an outpatient care addition that would allow VA to provide updated, modern outpatient care.

I take it you were not, on behalf of the Paralyzed Veterans of America, recommending a freeze on major construction at this point?

Mr. POWELL. I'm not recommending a freeze, but given the fact that we've got to come up with the money somewhere——

Mr. STEINBERG. OK.

Al.

Mr. PTAK. Thank you, Jon.

I just want to remind everybody that there is no plan for any new hospitals in Alaska. [Laughter.]

Many of you have mentioned the desire to expand the entitlement for outpatient care, long-term care, and so forth, and we've gotten mixed signals on how much that will be. The VA estimates it would be about $1 billion. Do you have any figures on how much it would be?

Mr. POWELL. I would be happy to provide figures for the record. $1 billion is nowhere near close to what we see. If you take into consideration offsets from Medicaid and Medicare—I'm trying to remember now, and I'd give you an inaccurate answer—but I'd be happy to provide those figures for the record.

Mr. STEINBERG. Al, as I recall, I think the Independent Budget attached a figure of some $380 million or something in that range for the outpatient entitlement, not including long-term care. I don't know what the cost was for long-term care.

Mr. PTAK. Does that sound about right, Jack?

If you could provide that, we'd appreciate it.

The other thing is I think what we've heard over the last couple of weeks, as there is some uncertainty in funding that the VA would have or what we even foresee—if there is the Mission Commission, if it does get off the ground, how do you think the uncertainty in funding for this year and for the future should enter into

the decisionmaking process? In other words—the chicken and the egg question—should the funding outlook kind of take priority and then see how the system fits in, or should it be the other way around, don't worry about the money, but just look at the health care?

Mr. SOMMER. If a true survey of the system is going to be done in a study, it can't be limited by the amount of dollars that are currently available, or have been available in the past. We'll have to take a look at what recommendations are made by the Commission and then take a look at what it would cost to fund those in the future because we're looking at a different type of veteran population. We're looking at an aging veteran population which requires additional services, and many times more expensive services, so if the recommendations of this Commission were suppressed by budgetary restraints of the now and the past, then it wouldn't be worthwhile carrying out the survey.

Mr. POWELL. Mr. Kennedy asked a very interesting question along these lines. He uses the example, if I might, of some hospitals in the Boston area, and he said, "OK, the hospital's sitting there and it's 40 percent empty. It's 40 percent empty because I've only been allocated X amount of staff and I need the staff for that total allocation to care for 60 percent of the patients, and the dollars."

Do you now come along and review this hospital and say, "Well there's 40 percent excess capacity at this hospital," and thereby reduce the numbers which then result in an arbitrary allocation of a reduction of staff which was my point back in my testimony about the need for staffing guidelines. That's where we get into part of this trouble because we don't know how many of what it takes to operate anything, so how can we make a determination about how much we can consolidate or cut in order to come out at a functioning level.

What comes first ought to, in my opinion, be title 38. Title 38 says that veterans are eligible to this care, entitled to that care. How do we deliver that in a cost-effective, quality way, and what does it take? That's why there is a Senate and a House of Representatives, to make some tough decisions and decide whether you want to cut back on that or allocate the funds for it.

The process of the Commission ought to be, as we had always envisioned the Commission, setting forth a fair and honest statement of the best way to deliver care based on the way the law stands, and then let the process go forth from there.

Mr. CULLINAN. The Veterans of Foreign Wars would concur with Mr. Sommer's remarks that you can't have this absolute limitation. On the other hand, we would also add that there has to be, at the very least, the assumption of current law entitlement.

Mr. PTAK. Tom.

Mr. SHERWOOD. Yes, I concur.

Mr. PTAK. Thank you all very much.

Mr. POWELL. The answer to your question—Richard was kind enough to whisper into my ear—the Independent Budget identifies $338 million dollars approximately for the cost of expanding entitlement for outpatient care to all category A. That is a pure cash cost. Under various scenarios that is offset by other costs by the

Federal Government to bring it down. In no scenario could we find that the cost would be greater than the $60 million estimate of CBO.

Mr. STEINBERG. What that did not include was the second part of Al's question which was nursing home long-term care, so if you would each provide the Committee with whatever estimate you have in that area, we'd certainly appreciate it.

It looks like you're about to receive another message. [Laughter.]

Thank you all for being with us this morning. We're sorry that Senator Cranston had to leave somewhat early, but we're glad that he was able to be here for most of your testimony.

Mr. POWELL. Thank you.

Mr. STEINBERG. Our final panel this morning is composed of Steve Kreisberg, the Executive Director of the National Federation of Federal Employees; Claudette Morrissey, the President of NOVA, the Nurses Organization of the Department of Veterans Affairs; and Dr. Paul Schafer, the Executive Director of the National Association of VA Physicians.

These groups represent many of the men and women throughout this country who are caring today, as we meet, for our veterans in VA facilities around the country. We look forward to what these organizations have to say about a Commission to review and make recommendations for the future of VA health care.

Again, as Senator Cranston said before, he had to leave to go to the Senate Floor. Let me express his regrets at not being able to be here for your testimony. We've obviously had your prepared testimony well in advance for well over a week now, so we have been able to review it at length and summarize it.

We appreciate you coming back again today, and apologize for the inconvenience caused last week.

Mr. Kreisberg, would you please lead off with your testimony?

STATEMENT OF STEVE KREISBERG, EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Mr. KREISBERG. Thank you, Mr. Steinberg.

Mr. STEINBERG. Summarize in 5 minutes, please.

Mr. KREISBERG. Sure.

On behalf of the National Federation of Federal Employees, which represents 14,000 employees of the Department of Veterans Affairs, most of whom work at these VA hospitals and outpatient clinics which we've been discussing, I appreciate the opportunity to submit our views on the proposed VA Commission on the Future Structure of Veterans Health Care.

We believe it is appropriate and necessary for the Department of Veterans Affairs to undergo a complete review of the veterans health-care system and for adjustments to be made to assure continued high quality care for veterans during the coming years. We are concerned, however, that the manner in which this review will take place could result in the best intentions going awry. Even with the best intentions, a flawed review procedure will inevitably produce a flawed result.

For example, we had serious concerns and objections to the procedures utilized by another recent Commission established to effect

the recent military base closures. In fact, we filed suit in Federal court to prevent that Commission's recommendation regarding military base closures from becoming reality. We urged the court to find that the process by which the recommendations were reached to be unconstitutional and a violation of the Administration Procedure Act. That case is currently pending in court.

Specifically, the Base Closure Commission's report was replete with erroneous and out-of-date information. We felt that the Commission failed to fulfill its obligations to Congress and the Nation. That Commission was set up originally by the Secretary of Defense as an advisory panel, much like the proposed VA Commission that we're discussing today. By passing the Base Closure Act in October of 1988, however, Congress gave that Commission almost unfettered discretion regarding which U.S. military facilities to close or realign. When Congress failed to override the "all or nothing" recommendations of the Commission, its recommendations became law. The result is flawed public policy. We cannot let it happen again.

In light of the National Federation of Federal Employee's dissatisfaction over the process utilized by the legislatively mandated Base Closure Commission, the establishment of yet another Commission, this time for the VA, gave us great cause for concern. It appears, however, that notwithstanding the consideration of these bills, Mr. Derwinski is establishing a 15 member Advisory Commission to study the future needs of the VA. We expect that the VA Commission's recommendations will be purely advisory in nature as opposed to the "all or nothing" choice that was offered by the Base Closure Commission and that has been proposed in both Senate bills. We urge that the VA Commission remain purely advisory, leaving to Congress the flexibility to establish a coherent public policy.

There are other important lessons to be gleaned from the Base Closure Commission's experiences as well. For example, we strongly urge that the Commission conduct all of its hearings and meetings publicly and that the Commission make all of its determinations in public, rather than in private executive sessions. This would be in accordance with section 10 of the Federal Advisory Committee Act. We recommend further that the Commission's studies and recommendations be subject to the Freedom of Information Act.

It is also imperative that the VA Commission be given ample time to reach its conclusions so as not to rush to judgment. Any conclusions reached should be subject to public comment so as to air any overlooked information or dissenting views. For these reasons, we object to the provisions of S. 1332 and S. 1398 which exempt the Commission from public disclosure requirements.

Along these lines, we believe that input from the National Federation of Federal Employees and other organizations representing VA employees regarding what is needed and most efficient is essential. While the Commission's mission remains vague and focused primarily on future service delivery to veterans, any realignment or mission change will have a major impact on the staff of the VA.

The paramount issue facing the Commission is how to organize the VA system to serve veterans in the most effective and efficient

manner. Any conclusion to this query that are made without input from the employees who deliver the services would be incomplete at best.

We strongly urge that the 15 member Commission have representation from employee groups. For this reason, we cannot support S. 1332, which, for reasons unknown, explicitly prohibits employees of the Department of Veterans Affairs from serving on the Commission.

At a minimum, we feel that there must be some formal mechanism whereby unions representing VA employees will have input into the Commission's decision process.

There has not been a wealth of information given thus far regarding the specific goals that the Secretary has set up for his Commission. The two bills before us today differ on key definitions, which would dictate the scope of the Commission's mission. We urge that the Commission and the Oversight Committee adopt the view that the term realignment does not mean closures, as defined in S. 1332.

As care providers, we are concerned that any mission change might adversely affect thousands of currently eligible veterans for whom this Nation has already extended a commitment of care. For instance, in the New York City area, it is estimated that as many as 100,000 veterans suffer from what is termed "non-service-connected" medical problems, such as mental illness. And in most cases, there are not reasonable alternatives for health care. What will happen to these veterans if the Commission decides that the mission of the VA should no longer encompass a commitment to these persons?

That concludes our statement, and I'll be happy to answer any questions later on.

[The prepared statement of the National Federation of Federal Employees appears on p. 140.]

Mr. STEINBERG. Thank you very much. I just might comment, since you made that recommendation, that I believe you were here last week when Senator Cranston raised questions to Secretary Derwinski with respect to recommendations from Federal employee organizations. He said that he would welcome those recommendations. We would encourage you, and other such organizations, as well as, obviously, both on this panel today, to submit those recommendations to him. He also had, as you recall, a dialogue with the Secretary about the importance of having on the Commission an individual who has been a long-time VA employee.

I just wanted to followup on that directly following your testimony.

Ms. Morrissey, we welcome you here. You're an old friend and a familiar face. We also welcome Ms. Davis who is appearing with you. Would you please proceed to summarize your statement.

STATEMENT OF CLAUDETTE MORRISSEY, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS, ACCOMPANIED BY BETTE DAVIS, LEGISLATIVE CHAIRPERSON

Ms. MORRISSEY. Thank you. I just wanted you to know that Ms. Davis is our Legislative Chair and she does work here at the Washington, DC VA. I'm very pleased that she's with me today.

Mr. Chairman and members of the Committee, on behalf of the Nurses Organization of Veterans Affairs, I thank you for the opportunity to present our comments and recommendations on the appointment of an independent Commission to examine and report on the future structure of the entire VA health-care system as well as on S. 1332 and S. 1398.

Since it has always been the Nurses Organization of Veterans Affairs' goal to help assure that veterans needing health care promptly receive quality care, Nurses Organization of Veterans Affairs commends Secretary Derwinski and shares his belief that "it is imperative that the Department improve the structure, organization, and delivery of VA health care services."

We agree that the time has come to review the VA health-care system to assure that it is able to meet the obligation this Nation has to care for the men and women who have served in the defense of our country.

Continued alterations in eligibility and access to veteran health care, combined with continual inadequate funding, do trigger concerns regarding the system's viability. In the midst of a health-care crisis in our country, the results of the Commission's study may provide the opportunity to improve a system that could be a model for the provision of care in the future.

The VA health-care system offers much to this Nation and has served, and continues to serve, as a model in many areas. VA is presently the Vanguard in health-care programs for gerontology, long-term care, AIDS, PTSD, spinal cord injury, severe and chronic psychiatric problems, alcohol and substance abuse, and the homeless.

A review of the mission and reorganization for improved efficiency are noble goals. The Nurses Organization of Veterans Affairs has no objection to the Commission being charged with these goals. We do, however, prefer the definition of realignment as stated in S. 1398, and object to the definition of realignment as stated in S. 1332, because it appears to indicate a primary goal of reductions and relocations of functions and staff. We fear that this will serve the agenda of some who wish to see only VA consolidations and closures and not improvements. The Nurses Organization of Veterans Affairs strongly supports the belief that the Congress and the veterans' service organizations have a role to play in the Commission's review and recommendations for the future of the veterans' health-care system.

The Nurses Organization of Veterans Affairs supports a VA mission of primary acute care, long-term care, ambulatory care, and home care. It is evident to the nurses at the bedside that veterans who require hospitalization need to be able to receive outpatient services in many forms such as outpatient clinic treatment, in-

creased direct patient services by HBHC, and expanded adult day health care, to name a few.

Nurses are the largest number of direct care providers in the VA system, and are crucial to the continuum of care. It is the Nurses Organization of Veterans Affairs expectation that the voice of nursing will be heard during the development of strategic plans, and whenever decisions are made about VA health care, whatever the level or stage they are at.

The Nurses Organization of Veterans Affairs urges the appointment of at least two professional nurses to the Commission, for the expertise of nurses on the Commission will help assure that the decisions being made will be evaluated for the impact on veteran patients, as well as the impact on the VA health-care system.

It is the Nurses Organization of Veterans Affairs hope that when the time comes for this Committee to review the recommendations of the Commission, you will evaluate and support the recommendations that will improve the ability of VA health-care professionals to provide the quality health care that is a promise and a commitment made to the men and women who have served in the defense of this Nation.

Thank you for the opportunity to present this statement.

[The prepared statement of Ms. Morrissey appears on p. 141.]

Mr. STEINBERG. Thank you very much, Claudette.

Dr. Schafer, we welcome you. You've been here many times before, and we're delighted to have you this morning.

STATEMENT OF DR. PAUL W. SCHAFER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS

Dr. SCHAFER. Mr. Chairman, the conclusion cannot be escaped that a major undertaking is being proposed. However, the question arises, if perchance too much is not being asked of too few, in too short a period of time, and perhaps, even at the wrong time. These are our concerns.

Absent a meaningful supplemental appropriation for the current fiscal year, the Commission will begin its work just as the system enters its last fiscal year 1990 quarter of agonal fiscal distress. Commission members will see clear evidence that denial of care has become a tool lay mangers have used for resource conservation.

They will share our concern that lay managers will shortchange health-care functions and those who provide them, favoring instead their own administrative fiefdoms.

You can judge for yourselves how you would characterize the January 1990 Cincinnati Medical Center plan which appears in my submitted testimony. This can't be called management. It is nothing short of administratively sanctioned malpractice. If allowed to continue and spread, we will be left with the equivalent of old movie sets, the empty shells of hospitals.

But the bulk of the Commission's work will occur during fiscal year 1991, the VA medical program funding for which the Administration has been much praised, since it represents a billion dollar increase over the admittedly inadequate fiscal year 1990 level. However, on careful analysis this increase almost completely fails

to focus on the vital and serious problems which have been voluminously documented.

Not a penny of this increase will go for desperately needed maintenance, modernization, and procurement of health-care equipment.

No constructive rational through processes could possibly have been involved in the Administration's proposed solution for the impending catastrophe represented by the program's inability to compete in the marketplace for first-class health-care providers. The proposal to offer only a $31.4 million pay raise for nurses—that's less than a $1,000 increase per nurse per year—only a $38.6 million pay raise for physicians and dentists—that's less than $3,000 per person per year—and nothing for other critical health-care providers is, in our words, nothing less than adding insult to injury, to which was then added a reduction in funding for research.

Absent a substantial congressional action to increase the pay of VA health-care professionals, the Commission will come face-to-face with an almost gutted professional staff serving in our health-care facilities. And the Department itself must bear a large measure of responsibility for this circumstance. Under duress, last Fall, its leadership team sent to the congressional committees a so-called Quadrennial Report concerning the recruitment and retention of VA physicians and dentists.

It contains a very serious flaw, its misleading bottom-line cost of $76 million. It funds $56 million of its pay improvements by reducing our existing primary special pay by $5,000 per person. Absent this retrogressive factor the bottom line cost would be $132 million, this more nearly approximating the amount needed to fund an adequate pay increase.

And now we come to our greatest concern about the Commission. By now few informed persons doubt that successive Administrations and their conservative advisors intend to do away with the veterans medical program as we now know it.

We suggest that all interested parties should be on notice that the recommendations of this Commission may become a "Trojan Horse" among us. First insight into this prospect will come with the identification of those selected to serve as Commission members. We suggest that we look them over carefully, and watch their actions like a hawk.

It would surely be ironic if veterans were to be robbed of their health care at a time when, with peace breaking out all over, there will actually be a peace dividend. Giving veterans a deserved share of this dividend would be poetic justice.

[The prepared statement of Dr. Schafer appears on p. 143.]

Mr. STEINBERG. Thank you very much, Dr. Schafer.

Thank each of you for staying within the summary guidelines.

Claudette, I know you were here last week and you heard Senator Cranston's exchange with the Secretary with respect to representation of nursing and an experienced chief nurse on the Commission to which the Secretary responded, "I think there is a very strong possibility."

We would hope and expect that would result in there being an individual with that kind of experience and that degree of sensitivi-

ty to direct patient care needs represented on the Commission as well.

Just so we can be very clear for the record, from each of you, does your organization support, oppose, or have no position on the Secretary's proposal to create the Commission that he has described for the Committee administratively?

Let's start with Mr. Kreisberg.

Mr. KREISBERG. Well, theoretically, we can support it. We're extremely concerned about its implementation. We had a disastrous experience within the Department of Defense, which we explained in our testimony. The level of trust that we have for the Secretary is not very high, frankly. His agenda is very possibly out there, which was alluded to by Dr. Schafer as well. But in theory, yes, it's a great idea to look at the VA's mission, to plan for the future, and to do that as a management function is essential. The way that it would be done is something that gives us a lot of concern and especially when we're talking about secrecy, unavailability of records, and what types of——

Mr. STEINBERG. There is no secrecy, in that sense, associated with the deliberations of the administrative Commission because it must comply with the National Advisory Committee Act, as you pointed out. My question was just the Administration Commission which the Secretary has proposed, not the legislatively created commissions that the two bills would establish.

So you are not opposed, certainly?

Mr. KREISBERG. We support it conceptually, yes.

Mr. STEINBERG. OK.

Claudette, can the Nurses Organization of Veterans Affairs State whether or not it supports, opposes, or takes no position on the administratively established Commission?

Ms. MORRISSEY. Well we support the concept, but we have some strong reservations because of the nondefined present eligibility and services, but we do support the concept.

Mr. STEINBERG. Dr. Schafer.

Dr. SCHAFER. Yes, we support the basic idea behind the administrative establishment of this Commission. But, from my submitted testimony, as well as from my remarks made here today, it's apparent that we have grave reservations about this, and we will be watching with great skepticism what does happen during this next 18 months.

Mr. STEINBERG. Thank you to each of you.

Dr. Schafer, with respect to your comments in your prepared statement, and in your statement this morning, about the adequacy of the fiscal year 1991 budget request—I'm sure you're aware of the recommendations that this Committee has submitted to the Budget Committee which would add well over $400 million, under present statutory authority, to the approximately $950 million that the Administration has proposed as an increase in fiscal year 1991. So this Committee is on a similar wave length in that regard with you.

We also thank you for your comments on the Administration's anticipated physician pay legislation, which of course has not been submitted yet. As you know, Senator Cranston has indicated that he plans to introduce legislation providing for increased pay for VA

doctors in the next month or so, and we will look forward to getting your organization's views on that legislation at a forthcoming hearing.

We'd also like to thank you for the material that you've submitted to us in the last several days from the American Association of Medical Colleges in terms of comparisons between various levels of pay for academic physicians and VA physicians. We appreciated getting that input from you, and want you to know that we welcome that. We'll also welcome your future participation.

Dr. SCHAFER. Thank you.

Mr. STEINBERG. Last week Senator Cranston asked Secretary Derwinski about the real and perceived possibilities that the Commission and its staff might not be independent of VA's agenda. And you heard further dialogue about that this morning with respect particularly to the composition of the staff of the Commission and its being almost entirely composed of current VA staff detailed to the Commission.

Would each of you care to comment on whether you have a concern about the real or perceived independence of the Commission set up in that fashion?

Let's start with Dr. Schafer this time.

Dr. SCHAFER. We find it very difficult to avoid the perception that there will be an enormous influence on the Commission by the fact that all of the staff are employees of the Department. It is a very subtle mechanism that is involved here, but the fact is that they are employees of the Department, and they certainly are sensitive in many different ways to seeing that the wishes that are known throughout the system are not compromised, or at least that they would not become identified with such compromise.

That is a very difficult role that will be asked of the individual staff members who will be doing obviously the bulk of the work of the Commission. I'm fearful that the perception will remain over the next 18 months that such factors are operating.

Mr. STEINBERG. Do you think that perception would be ameliorated if there were independent staff, that is outside staff, as well as detailed staff?

Dr. SCHAFER. I think it would be much better if there were a mixture of VA personnel and outside, obviously uncompromised staff members. I fear that if we have nothing but VA employees as the staff members supporting the work of this Commission it will be extremely difficult to avoid at least the perception, if not the fact, other than what we would like to see as the objective basis for whatever the Commission concludes.

Mr. STEINBERG. Thank you.

Mr. Kreisberg.

Mr. KREISBERG. We endorse generally what Dr. Schafer said. I believe that we're kind of at the horns of the dilemma here. If you don't have VA staff involved in the Commission, you don't have the institutional expertise. If you have them you're at the risk of it being touted as the Secretary's Commission, belonging to the Secretary with expectations from high management going down to the members. The balance is needed, outside and staff. Yet, that balance is needed. I think what's also needed is for Committees like this one to carefully review any recommendations to air these

things out publicly so that anybody can offer their views at that time, and leave it to the decision makers to find a solution.

Mr. STEINBERG. Thank you.

Ms. Morrissey.

Ms. MORRISSEY. I don't really have that much of a problem with the perception with the staff being all VA, although I believe a mixed bag would be better. I think you're going to have a problem with perceptions when you hear that the commissioners, or the people who are actually serving on the Commission, although they are not VA employees, the final OK has been given by the Secretary for them to serve on that Commission. That's where I'm afraid your perception might come in, although I personally don't feel that. I think that's where your perception would come in, rather than at the staff level.

Mr. STEINBERG. Are you suggesting that since the appointment of commissioners will emanate from the Secretary with no other check on that appointment, it would be perceived that this would be a Commission to carry out his agenda, whatever that might be?

Ms. MORRISSEY. I don't feel that way personally, but I think that's where your perception would come in, rather than at the staff level.

Mr. STEINBERG. Mr. Kreisberg, your statement that this Commission "could result in the best intentions going awry" may be, in the ultimate, the best summary of all the concerns expressed this morning. If we knew in advance that the appropriate questions would be asked by people with the appropriate expertise and independence backed up by a staff with the appropriate expertise and independence and that the Commission's recommendations would enhance the care of veterans and not detract from it, it's very doubtful that anyone would object to the Commission, or have any reservations about it. But of course, those are things that we can't know in advance, even with the best of expectations and trust.

We thank all of you and the other witnesses this morning, for highlighting those concerns. We hope very much that the Secretary, the Deputy Secretary, and Ms. Quandt, who is here with us this morning, at this point in the hearing, will listen carefully to your suggestions. We certainly intend, as you suggested, and as the other witnesses suggested, to followup on many of those concerns and to monitor the Commission's progress as it develops. So we thank you for those expressions of concern, and want you to be assured that we will follow the Commission's work very closely.

Midge, we greatly appreciate you remaining here throughout the hearing this morning to listen to what the other witnesses had to say, and we hope that you will take their views very seriously into account.

Al.

Mr. PTAK. Thank you, Jon.

I'd just like to get from each of you, just for the record, on how you feel about having the closure of facilities included in the Commission's abilities?

Dr. Schafer.

Dr. SCHAFER. We did not comment about the two bills, the subject of this hearing, but I believe that you will find from my submitted testimony—and I guess from my oral remarks—we do not

support either one of those bills. We recognize that the Commission has been administratively established, that's part of the reason, but beyond that we just view with great skepticism anything that relates to administratively originated attitudes about reductions, changes, and closures, because as I have said, and as I submitted in my testimony, the record is clear. This Administration and its two preceding Administrations, and some of the administrative instruments of prior Administrations have clearly documented their intention really to get rid of the Veterans Medical Program, so we're just very suspicious, and this would extend to the concept of closures.

Ms. MORRISSEY. The Nurses Organization of Veterans Affairs would not like to see any closures of any veterans facilities. We welcome the opportunity to examine the system to ultimately give better care. We can understand some realignments, and even some major mission changes. I work at the Brooklyn VA, and I know what you're talking about because Brooklyn and Manhattan are right there together, and I can understand that. But, no, we would not be very happy to hear about any closures. I don't think that would be in the best interest of the veterans.

Mr. KREISBERG. As a representative of employees of these hospitals, I'm not going to endorse putting our members out of work, but I think as a matter of public policy, if it's objectively demonstrated that the closure of facilities is best for the veterans, best for the Department of Veterans Affairs, and best for the taxpayer, we would go along provided that there were measures taken to take care of the employees who were affected.

Mr. PTAK. My last question is to Dr. Schafer. On page 2 of your testimony, you say that there is evidence that "the Department of Veterans Affairs Secretary and his Deputy would not be uncomfortable managing the Department with less, rather than more, input from VHS&RA health professionals, who still remain in titular leadership positions." You also question the health-care expertise that one could find on the 10th floor of the departmental headquarters. You end that statement by saying—it's almost talking about the health-care delivery of the VA being similar to a chain of Howard Johnson Motels. Do you have evidence to support that statement?

Dr. SCHAFER. Yes, I do, otherwise I wouldn't have made it. The way I characterized the situation that exists on the eighth floor of the headquarters building, I said that among the health-care professionals there in VHS&RA, morale is at a rock bottom low.

Now to amplify that, because it bears directly on the answer to the question that you've asked, the reason for that is that it is my impression from those who have contacted our organization that they feel left out of what has been going on in the Department since it came into existence, that more and more of the decisions are being made without their input. They're being made from the 10th floor. The fact is that these are the people who know the most about what it is that we do in this Department, namely rendering health care to eligible veterans.

And perhaps mine was just a little bit pointed in the way that I phrased it, but I doubt that there is any health care expertise on the tenth floor of our Department. Where we have that is in the

eighth floor among VHS&RA officials who are there, not just in titular identification, but because of their expertise in this matter that we're concerned about, namely giving health care to veterans.

In my illustration of the Howard Johnson Motel, I just don't think there's any question but when you are delivering health care in a facility, you better know what it is you're talking about when you're making decisions about your principle product. We're not just talking about buildings, their maintenance, their external facade, and the efficiency with which their daily administrative operations are carried out—we're talking about delivering health care.

So that's the answer to your question. It really goes back to direct personal contact, not initiated by me, but initiated by the concerned individuals in VHS&RA. I would even go one step further, though I obviously can't attribute the source——

Mr. PTAK. That's OK. We're all friends here. [Laughter.]

Dr. SCHAFER. Well, I know, but there are those that are listening to my testimony, and those who will read the transcript, who will be very curious about the answer to this question. Our organization was actually approached by this unnamed individual representing a number of his and or possibly her colleagues in VHS&RA for NAVAPD to intercede on their behalf because of their concerns.

Mr. PTAK. This was on a specific incident or——

Dr. SCHAFER. This has to do with this statement I made about morale being at a rock bottom low.

Mr. PTAK. I understand.

Dr. SCHAFER. That's the basis for that particular statement.

Mr. PTAK. Thank you, Jon.

Mr. STEINBERG. Thank you very much, Al.

Again we thank all of you. Claudette, we appreciate your coming back to Washington, DC, a week after you originally came.

I also want to express our gratitude to the number of other VA officials who have remained throughout this hearing, Ralph Ibsen, Rich Robinson, John Bradley, Meg O'Shea, and Bob Moran. We appreciate your presence here this morning.

This hearing stands adjourned.

[Whereupon, at 11:45 a.m., the Committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

II

101ST CONGRESS
1ST SESSION

S. 1332

To provide for realignment and major mission changes of medical facilities of the Department of Veterans Affairs.

IN THE SENATE OF THE UNITED STATES

JULY 17 (legislative day, JANUARY 3), 1989

Mr. MURKOWSKI introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

A BILL

To provide for realignment and major mission changes of medical facilities of the Department of Veterans Affairs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Veterans Affairs Medical Facilities Realignment Act of 1989".

SEC. 2. REALIGNMENT AND MISSION CHANGES OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall—

(1) within 45 days after the date of the enactment of this Act, issue a charter establishing the Commission provided for in section 4 and containing the terms, conditions, and mandates for its operation to achieve its objectives under this Act, including provision for the appointment of staff and any other support and expenses the Commission considers necessary;

(2) realign all medical facilities recommended for realignment by the Commission in the report to the Secretary of Veterans Affairs pursuant to the charter establishing the Commission;

(3) change the major missions of medical facilities as recommended by the Commission in its report to the Secretary; and

(4) initiate all such realignments and major mission changes not later than one year after receipt of the Commission's report by the Secretary, and complete all such realignments and all actions required for such mission changes not later than three years after receipt of such report by the Secretary.

SEC. 3. CONDITIONS.

(a) IN GENERAL.—(1) The Secretary of Veterans Affairs may not carry out any realignment or major mission change of any medical facility under this Act unless—

(A) not later than 15 days after receiving the report referred to in section 2, the Secretary of Veterans Affairs transmits to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report containing a statement that the Secretary has approved, and the Department of Veterans Affairs will implement, all of the medical facility realignments and major mission changes recommended by the Commission in that report; and

(B) the Commission has recommended, in the report referred to in section 2, the realignment or major mission change as the case may be, of the medical facility, and has transmitted to the Committees on Veterans' Affairs of the Senate and the House of Representatives a copy of the report and the statement required by section 4(d)(2)(B).

(2) The Secretary may not initiate any realignment or major mission change recommended by the Commission in the report referred to in section 2 within 45 days after the committees referred to in paragraph (1) receive the Secretary's report pursuant to such paragraph.

(b) JOINT RESOLUTION.—The Secretary of Veterans Affairs may not carry out any realignments or major mission changes under this Act if, within 45 days after the committees receive the Secretary's report under subsection (a)(1), a

joint resolution is enacted, in accordance with the provisions of section 9, disapproving all the recommendations of the Commission. The days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of the 45-day period.

SEC. 4. THE COMMISSION ON MEDICAL FACILITY REALIGNMENT AND MAJOR MISSION CHANGE.

(a) NAME OF COMMISSION.—The Commission established pursuant to the charter issued by the Secretary of Veterans Affairs pursuant to section (2)(a)(1) shall be known as the "Commission on Medical Facility Realignment and Major Mission Change".

(b) MEMBERSHIP.—The Commission shall be appointed by the Secretary of Veterans Affairs and shall consist of not less than 9 and not more than 12 members, as follows:

(1) One member from among persons, if any, nominated by the Association of American Medical Colleges.

(2) One member from among persons knowledgeable about sharing Department of Veterans Affairs and Department of Defense health-care resources who are nominated by the Secretary of Defense.

(3) One member who is a member of the special medical advisory group established pursuant to section 4112(a) of title 38, United States Code.

(4) One member from among persons, if any, nominated by veterans service organizations chartered by Congress.

(5) One member from among persons knowledgeable about the Medicare and Medicaid programs who are nominated by the Secretary of Health and Human Services.

(6) The remaining members from among persons who, by reason of education, training, and experience, are experts in (A) the management of health services in private enterprise, (B) health care economics, (C) health care policy, (D) medical care furnished by the Veterans Health Services and Research Administration, except that no such member may be an employee of the Department of Veterans Affairs, (E) long-term health care services, and (F) rural health care services.

(c) CHAIRMAN AND VICE CHAIRMAN.—The Secretary of Veterans Affairs shall designate a Chairman and Vice Chairman from among the members of the Commission.

(d) DUTIES.—The Commission shall—

(1) transmit the report referred to in section 2(a) to the Secretary within one year after the date of the

enactment of this Act and shall include in such report the Commission's recommendations regarding the medical facilities to which functions should be transferred as a result of the realignments and major mission changes recommended by the Commission; and

(2) on the date on which the Commission transmits such report to the Secretary, transmit to the Committees on Veterans Affairs of the Senate and the House of Representatives—

(A) a copy of such report; and

(B) a statement certifying that the Commission has reviewed all medical facilities, including all medical facilities under construction and all those planned for construction, and has identified the medical facilities recommended for realignment or major mission changes.

(e) STAFF AND SUPPORT.—Not more than one-fourth of the professional staff of the Commission shall be individuals who have been employed by the Department of Veterans Affairs within one year before the date of the enactment of this Act.

(f) RECORDS AND MEETINGS.—(1) The records, documents, and other materials prepared by or for the Commission are not subject to section 552 of title 5, United States Code.

(2) Meetings of the Commission are not subject to the provisions of section 10 of the Federal Advisory Committee Act (5 U.S.C. App.).

SEC. 5. IMPLEMENTATION.

(a) IN GENERAL.—In realigning or changing the major mission of a medical facility under this Act, the Secretary of Veterans Affairs, subject to the availability of funds, including funds in the Account—

(1) may carry out actions necessary to implement such realignment or major mission change, including the acquisition of such land, the construction of such replacement facilities, the performance of such activities, and the conduct of such advance planning and design as may be required to transfer functions from such medical facility to another medical facility;

(2) may provide—

(A) economic adjustment assistance to any community located near a medical facility being realigned or whose major mission is to be changed, and

(B) community planning assistance to any community located near a medical facility to which functions will be transferred as a result of such realignment or major mission change,

if the Secretary determines that such assistance is needed and that the financial resources available to the community (by grant or otherwise) for economic adjustment and community planning are inadequate; and

(3) subject to the availability of funds referred to in clause (1), may carry out activities for the purpose of environmental restoration, including reducing, removing, and recycling hazardous wastes and removing unsafe buildings and debris.

(b) MANAGEMENT AND DISPOSAL OF PROPERTY.—(1) The Administrator of General Services shall delegate to the Secretary of Veterans Affairs, with respect to excess and surplus property located at a medical facility realigned under this Act—

(A) the authority of the Administrator to utilize excess property under section 202 of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 483);

(B) the authority of the Administrator to dispose of surplus property under section 203 of that Act (40 U.S.C. 484); and

(C) the authority of the Administrator to grant approvals and make determinations under section 13(g) of the Surplus Property Act of 1944 (50 U.S.C. App. 1622(g)).

(2)(A) Subject to subparagraph (B), the Secretary of Veterans Affairs shall exercise authority delegated to the Secretary pursuant to paragraph (1) in accordance with—

(i) all regulations in effect on the date of the enactment of this Act governing utilization of excess property and disposal of surplus property under the Federal Property and Administrative Services Act of 1949; and

(ii) all regulations in effect on the date of the enactment of this Act governing the conveyance and disposal of property under section 13(g) of the Surplus Property Act of 1944 (50 U.S.C. App. 1622(g)).

(B) The Secretary of Veterans Affairs, after consulting with the Administrator of General Services, may issue regulations that are necessary to carry out the delegation of authority required by paragraph (1).

(C) The authority required to be delegated by paragraph (1) to the Secretary of Veterans Affairs by the Administrator of General Services shall not include the authority to prescribe general policies and methods for utilizing excess property and disposing of surplus property.

(D) Before any action may be taken with respect to the disposal of any surplus real property at a medical facility in connection with a realignment under this Act, the Secretary of Veterans Affairs shall consult with the Governor of the

State and heads of the local governments concerned for the purpose of considering any plan for the use of such property by the local community concerned.

(E) The provisions of this paragraph and paragraph (1) are subject to paragraphs (3) and (4).

(3)(A) Before any action is taken with respect to the disposal or transfer of any real property at a medical facility in connection with a realignment or major mission change under this Act, the Secretary of Veterans Affairs shall notify all other departments, agencies, and instrumentalities (including nonappropriated fund instrumentalities) of the United States Government of the availability of such property, or portion thereof, and may transfer such property or portion, without reimbursement, to any such department, agency, or instrumentality. In carrying out this paragraph, the Secretary shall give a priority, and shall transfer, to any such department, agency, or instrumentality that agrees to pay fair market value for the property or portion. For the purposes of this paragraph, the fair market value shall be the fair market value as of the date of the transmittal to the Secretary of the report referred to in section 2(a).

(B) This paragraph shall take precedence over any other provision of this Act or other provision of law with respect to the disposal or transfer of any real property at a medical

facility in connection with a realignment or major mission change under this Act.

(4)(A) Except as provided in subparagraph (B), all proceeds—

(i) from any transfer under paragraph (3), and

(ii) from the transfer or disposal of any other property made as a result of a realignment or major mission change under this Act,

shall be deposited into the Account.

(B) In any case in which the General Services Administration is involved in the management or disposal of such property, the Secretary of Veterans Affairs shall reimburse the Administrator of General Services from the proceeds of such disposal, in accordance with section 1535 of title 31, United States Code, for any expenses incurred in such activities.

SEC. 6. WAIVER.

The Secretary of Veterans Affairs may carry out this Act without regard to—

(1) any provision of law restricting the authority of the Secretary or the use of funds for realigning medical facilities or changing the major missions of medical facilities, other than any provision of this Act;

(2) any provision of title 38, United States Code; and

(3) the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

SEC. 7. REPORTS.

As part of each annual budget request for the Department of Veterans Affairs, the Secretary of Veterans Affairs shall transmit to the Committees on Veterans Affairs and Appropriations of the Senate and the House of Representatives—

(1) a schedule of the realignment or major mission change actions to be carried out under this Act in the fiscal year for which the request is made and an estimate of the total expenditures required and cost savings to be achieved by each such realignment or major mission change and of the time period within which such cost savings are to be achieved in each case, together with the Secretary's assessment of the environmental effects of such actions; and

(2) a description of the medical facilities, including those under construction and those planned for construction, to which functions are to be transferred as a result of such realignments or major mission changes, together with the Secretary's assessment of the environmental effects of such transfers.

SEC. 8. FUNDING.

(a) ESTABLISHMENT OF ACCOUNT.—There is hereby established on the books of the Treasury an account to be known as the "Department of Veterans Affairs Medical Facility Realignment Account" which shall be administered by the Secretary of Veterans Affairs as a single account.

(b) DEPOSITS TO THE ACCOUNT.—There shall be deposited into the Account—

(1) funds appropriated to the Account for fiscal years beginning after the date of the enactment of this Act;

(2) any funds that the Secretary may, subject to approval in an appropriation Act, transfer to the Account from funds appropriated to the Department of Veterans Affairs for any purpose, except that such funds may be transferred only after the date on which the Secretary transmits written notice of, and justification for, such transfer to the Committees on Veterans Affairs and Appropriations of the Senate and the House of Representatives; and

(3) proceeds described in section 5(b)(4)(A).

(c) USE OF FUNDS.—(1) The Secretary may use the funds in the Account only for the purposes described in section 5(a).

(2) When a decision is made to use funds in the Account to carry out a major medical facility project (as defined in

section 5004(a)(3)(A) of title 38, United States Code) under section 5(a)(1) of this Act, the Secretary shall notify in writing the Committees on Veterans Affairs and Appropriations of the Senate and the House of Representatives of the nature of, and justification for, the project and the amount of expenditures for such project.

(d) REPORT.—Not later than 60 days after the end of each fiscal year in which the Secretary carries out activities under this Act, the Secretary shall transmit to the Committees on Veterans Affairs and Appropriations of the Senate and the House of Representatives a report on the amount and nature of the deposits into, and the expenditures from, the Account during such fiscal year and of the amount and nature of other expenditures made pursuant to section 5(a) during such fiscal year.

(e) FINAL ACCOUNTING AND CERTIFICATION.—When the Secretary completes all actions necessary for the realignments and major mission changes required pursuant to this Act, the Secretary shall—

(1) transmit to the Committees on Veterans Affairs and Appropriations of the Senate and the House of Representatives a report containing an accounting of—

(A) all funds deposited into and expended from the Account or otherwise expended under this Act; and

(B) any amount remaining in the Account; and

(2) transmit to the Secretary of the Treasury a certification that all such actions have been completed.

(f) DISPOSITION OF UNOBLIGATED FUNDS.—Upon receipt of a certification pursuant to subsection (e)(2), the Secretary of the Treasury shall transfer all unobligated funds remaining in the Account to the miscellaneous receipts account in the United States Treasury.

SEC. 9. CONGRESSIONAL CONSIDERATION OF COMMISSION REPORT.

(a) TERMS OF THE RESOLUTION.—For purposes of section 3(b), the term "joint resolution" means only a joint resolution—

(1) which is introduced within 45 days after the date on which the committees referred to in section 3(a) receive a report by the Secretary of Veterans Affairs pursuant to section 3(a)(1)(A), and—

(2) which does not have a preamble;

(3) the matter after the resolving clause of which is as follows: "That Congress disapproves the recommendations of the Commission on Medical Facili-

ty Realignment and Major Mission Change established by the Secretary of Veterans Affairs as submitted to the Secretary of Veterans Affairs on _____,'' the blank space being appropriately filled with the date; and

(4) the title of which is as follows: ''A joint resolution disapproving the recommendations of the Commission on Medical Center Realignment and Major Mission Change''.

(b) REFERRAL.—A resolution described in subsection (a) introduced in the House of Representatives shall be referred to the Committee on Veterans Affairs of the House of Representatives. A resolution described in subsection (a) introduced in the Senate shall be referred to the Committee on Veterans Affairs of the Senate.

(c) DISCHARGE.—If the committee to which a resolution described in subsection (a) is referred has not reported such resolution (or an identical resolution) within the 45-day period beginning on the date on which such resolution is introduced, such committee shall be discharged from further consideration of such resolution as of the day after the last day of such period, and such resolution shall be placed on the appropriate calendar of the House involved.

(d) CONSIDERATION.—(1) On or after the third day after the date on which the committee to which such a reso-

lution is referred has reported, or has been discharged (under subsection (c)) from further consideration of, such a resolution, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the resolution (but only on the day after the calendar day on which Member announces to the House concerned the Member's intention to do so). All points of order against the resolution (and against consideration of the resolution) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the respective House shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the respective House until disposed of.

(2) Debate on the resolution and on all debatable motions and appeals in connection therewith shall be limited to not more than 10 hours, which shall be divided equally between those favoring and those opposing the resolution. An

amendment to the resolution is not in order. A motion further to limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the resolution is not in order. A motion to reconsider the vote by which the resolution is agreed to or disagreed to is not in order.

(3) Immediately following the conclusion of the debate on a resolution described in subsection (a) and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the resolution shall occur.

(4) Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a resolution described in subsection (a) shall be decided without debate.

(e) CONSIDERATION BY OTHER HOUSE.—(1) If, before the passage by one House of a resolution of that House described in subsection (a), that House receives from the other House a resolution described in subsection (a), then the following procedures shall apply:

(A) The resolution of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subparagraph (B)(ii).

(B) With respect to a resolution described in subsection (a) of the House receiving the resolution—

(i) the procedure in that House shall be the same as if no resolution had been received from the other House; but

(ii) the vote on final passage shall be on the resolution of the other House.

(2) Upon disposition of the resolution received from the other House, it shall no longer be in order to consider the resolution that originated in the receiving House.

(f) RULES OF THE SENATE AND HOUSE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 10. DEFINITIONS.

In this Act:

(1) The term "Account" means the Department of Veterans Affairs Medical Facility Realignment Account established by section 8 of this Act.

(2) The term "major mission change" means any substantive change in clinical programs or patterns of delivery of medical care at a medical facility, or part thereof, pursuant to the terms and limitations contained in the charter referred to in section 2(a).

(3) The term "medical facility" means a Department of Veterans Affairs facility referred to in section 601(4)(A) of title 38, United States Code.

(4) The term "realignment" means closure, consolidation, and any other action which both reduces and relocates functions and civilian personnel positions.

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II

101ST CONGRESS
1ST SESSION

S. 1398

To provide for the realignment or major mission change of certain medical facilities of the Department of Veterans Affairs.

IN THE SENATE OF THE UNITED STATES

JULY 25 (legislative day, JANUARY 3), 1989

Mr. CRANSTON (for himself and Mr. MURKOWSKI) (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To provide for the realignment or major mission change of certain medical facilities of the Department of Veterans Affairs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Department of Veterans Affairs Health Care Quality Assistance and Cost Effectiveness Act of 1989".

SEC. 2. The Congress finds that:

(a) The Department of Veterans Affairs now provides quality health care to eligible veterans in one hundred and seventy-two medical centers, one hundred

and nineteen nursing homes, two hundred and thirty-three outpatient clinics, twenty-seven domiciliaries, and one hundred and ninety-four readjustment counseling centers throughout the United States, its territories and possessions.

(b) In the period since the establishment of most Veterans Affairs facilities, there has been a significant shift in the population of veterans within the United States. The population, especially older veterans, has moved south. Veterans Affairs medical centers, many of which were built after World War II, are maldistributed for today's eligible population. The total veteran population is projected to continue to decline, while the percentage of veterans who are elderly will significantly increase.

(c) Also, within this period, there have been major advances in medicine, which have reduced the prevalence of diseases and revolutionized the treatment of disorders for which certain Veterans Affairs medical centers had originally been established. At the same time, new or previously unknown health-care problems and diseases, which require specialized treatment facilities, have emerged since the end of the Second World War. The practice of medicine has changed from hospital-based care to a continuum which incorporates am-

bulatory as well as inpatient and extended care and community-based outreach care.

(d) There has not been a thorough review in at least twenty-five years to determine the most optimal and efficient distribution of health-care resources to veterans.

(e) Quality of care is the benchmark of a successful, acceptable health care system. The definition of quality of care encompasses the environment, materials, clinical processes, and available clinicians and practitioners. A major review and evaluation of all Veterans Affairs health-care facilities, which would include consideration of realignments or facility mission changes, are needed to assure that the Veterans Health Services and Research Administration can continue to provide quality care effectively and efficiently while meeting its goal of affording eligible veterans equitable access to that care.

(f) The cooperation and collaboration between the health-care systems of the Departments of Defense and Veterans Affairs pursuant to recent legislation has resulted in numerous "sharing agreements" allowing resources to be utilized more fully.

(g) A review, evaluation, and development of recommendations for needed changes in the Veterans

Health Services and Research Administration can best be conducted by an independent, bipartisan, broadbased commission, composed of leading citizens, particularly those with health-care leadership and expertise.

SEC. 3. IN GENERAL.—(a) The Secretary of Veterans Affairs is authorized to—

(1) realign all medical facilities recommended for realignment by the Commission provided for in section 5 in its report to the Secretary of Veterans Affairs;

(2) change the major mission of all medical facilities as recommended for such change by the Commission in such report; and

(3) initiate all these realignments and major mission changes no later than two years after receipt of the Commission's report to the Secretary, and complete all realignments and major mission changes no later than six years after receipt of the report.

It is the sense of the Congress that under no circumstances shall the Secretary of Veterans Affairs revise the recommendations of the Commission.

SEC. 4. CONDITIONS.—(a) IN GENERAL.—The Secretary may not carry out the realignment and major mission change of any medical facility under this Act unless the Secretary transmits to the Committees on Veterans' Affairs of the Senate and House of Representatives a copy of the report

referred to in section 3 and a report containing a statement that the Secretary has approved, and the Department of Veterans Affairs will implement, the medical facility realignments and major mission changes recommended by the Commission in its report.

(b) JOINT RESOLUTION.—The Secretary of Veterans Affairs may not carry out any realignments or major mission changes under this Act if, within four months of the transmittal of the report by the Secretary to the Committees on Veterans' Affairs of the Senate and House of Representatives, a joint resolution is enacted in accordance with the provisions of section 10, disapproving all the recommendations of the Commission. The joint resolution shall only provide for disapproval of all recommendations and may not delete or amend any recommendation for realigning or changing the major mission of any medical facility. The days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of the four-month period.

(c) TERMINATION OF AUTHORITY.—The authority of the Secretary of Veterans Affairs to carry out any realignment or major mission change under this section shall terminate six years after the date of the receipt of the report referred to in section 3.

SEC. 5. THE COMMISSION ON REALIGNMENT AND MAJOR MISSION CHANGE.—(a) MEMBERSHIP.—The Commission shall consist of not less than nine and not more than fifteen members selected by the Secretary of Veterans Affairs:

(1) Recommendations may be offered for selection of members of the Commission as follows—

(A) one member recommended by the chairman, and one member recommended by the ranking minority member, Committee on Veterans' Affairs, United States House of Representatives;

(B) one member recommended by the chairman, and one member recommended by the ranking minority member, Committee on Veterans' Affairs, United States Senate;

(C) one member recommended by the Association of American Medical Colleges, after consultation with the Chief Medical Director of the Veterans Health Services and Research Administration; and

(D) two members recommended by veterans' service organizations chartered under title 38, United States Code.

(2) The Chief Medical Director may also recommend members, including—

(A) one member who is a member of the Special Medical Advisory Group established pursuant to authority in section 4112(a) of title 38, United States Code;

(B) one member who is knowledgeable of and familiar with the health-care system of the Department of Defense and the sharing of health-care resources between the Departments of Defense and Veterans Affairs;

(C) two members with broad experience in government or private enterprise; and

(D) persons representing clinical care, medical research, and educational activities affected by the Veterans Health Services and Research Administration or persons with experience in the management of health services and research programs, or health-care economics or policy.

(3) The Secretary of Veterans Affairs shall designate, after consultation with the Chief Medical Director, a Chairman and Vice Chairman from among the members of the Commission.

(b) DUTIES.—The Commission shall—

(1) review each medical facility of the Department of Veterans Affairs on its ability to meet the health-care needs of, and provide quality care to, eligible vet-

erans currently residing in the area served by the facility and eligible veterans who will be residing in that area according to demographic projections;

(2) include the following factors in developing the criteria to be used in conducting its review: the population and health-care needs of eligible veterans in the area served by the facility who are likely to use Veterans Affairs facilities with particular emphasis on the needs of those veterans whose care Veterans Affairs is obligated by law to provide, specialized health-care services provided, the facility's workload, alternative sources of health care for veterans in the area served, the impact of the medical facility on the community's health care and economy, the facility's physical plant, the ability to recruit and retain qualified health-care personnel, and quality of care; and

(3) strive to achieve the goal of more efficient delivery of quality care to eligible veterans in the area where they reside.

(c) REPORT.—(1) The Commission shall transmit the report referred to in section 3 to the Secretary of Veterans Affairs no later than January 1, 1991.

(2) The report shall include the following:

(A) a description of the Commission's recommendations of the medical facilities from or to which func-

tions will be transferred as a result of the realignments or major mission changes recommended by the Commission;

(B) a statement certifying that the Commission has identified the medical facilities to be realigned or changed in their major missions by reviewing all medical facilities, including medical facilities under construction and all those planned for construction under the Department of Veterans Affairs five-year medical facility development plan; and

(C) a statement of the estimated costs and savings related to each of the realignments and major mission changes recommended by the Commission.

(d) SUPPORT.—The Commission is authorized to employ staff and obtain other support services and resources to carry out its duties. The Secretary of Veterans Affairs may provide the Commission, on request, with support services available, including staff, space, and equipment. Funds from the Medical Care appropriation account of the Department of Veterans Affairs may be used for expenses incurred by the Commission in carrying out its duties, subject to the availability of appropriations. Not more than one-half of the professional staff of the Commission shall be individuals who have been employed by the Department of Veterans Affairs during the year prior to the enactment of this Act.

(e) RECORDS AND MEETINGS.—(1) All records, documents, and other materials generated by the Commission from the date of its establishment shall not be subject to the Freedom of Information Act (5 U.S.C. 552).

(2) No meeting of the Commission shall be subject to the provisions of section 10 of the Federal Advisory Committee Act (5 U.S.C. App. 2, and 5 U.S.C. 552b).

(3) No member of the Commission or any person employed by or assigned to the Commission or any official or employee of the Department of Veterans Affairs may reveal or disclose any records, documents, or other materials generated by the Commission to anyone other than officers or employees of the United States until the Secretary of Veterans Affairs transmits to the Committee on Veterans' Affairs of the Senate and House of Representatives the report provided in section 4(a).

SEC. 6. IMPLEMENTATION.—(a) IN GENERAL.—In realigning or changing the major mission of a medical facility under this Act, the Secretary of Veterans Affairs—

(1) subject to the availability of funds authorized for and appropriated to the Department of Veterans Affairs for use in planning and design, construction, or operation and maintenance, and the availability of funds in the fund established under section 9 of this Act, may carry out actions necessary to implement

such realignment or major mission change, including the acquisition of such land, the construction of such replacement facilities, the performance of such activities, and the conduct of such advance planning and design as may be required to transfer functions from one material facility to another medical facility;

(2) subject to the availability of funds authorized and appropriated to the Department of Veterans Affairs for economic adjustment assistance or community planning assistance and the availability of funds in the fund established under section 9 of this Act, shall provide—

(A) economic adjustment assistance to any community located near a medical facility being realigned or whose major mission is to be changed, and

(B) community planning assistance to any community located near a medical facility to which functions will be transferred as a result of such realignment or major mission change,

if the Secretary determines that the financial resources available to the community (by grant or otherwise) for such purposes are inadequate; and

(3) subject to the availability of funds authorized and appropriated to the Department of Veterans Af-

fairs for environmental restoration and the availability of funds in the fund, may carry out activities for the purpose of environmental restoration, including reducing, removing, and recycling hazardous wastes and removing unsafe buildings and debris.

(b) DISPOSAL OF PROPERTY.—(1) The Administrator of General Services shall transfer and dispose of all property and facilities of the Department of Veterans Affairs located at a facility to be realigned or whose major mission is to be changed pursuant to this Act in accordance with the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 471 et seq.) and other laws which authorize the Administrator to dispose of property of agencies of the United States and without regard to section 5022(a) of title 38, United States Code.

(2)(A) Subject to subparagraph (B), the Administrator of General Services shall deposit into the fund established under section 9 of this Act all proceeds transferred or disposed of by the Administrator of General Services pursuant to this Act.

(B) The Administrator of General Services shall deposit into the fund referred to in section 204(b) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 485(b)) an amount of the proceeds of each transfer and of each disposal of property carried out pursuant to this Act equal to the amount estimated by the Administrator to

be needed for direct expenses incurred by the Administrator in carrying out the transfer or disposal, as applicable. Amounts deposited by the Administrator into that fund pursuant to this subsection shall be administered in accordance with sections 204 (b), (c), and (d) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 485 (b), (c), and (d).

SEC. 7. WAIVER.—The Secretary of Veterans Affairs may carry out this Act without regard to—

(1) any laws restricting the authority of the Secretary or restricting the use of funds for realigning or changing the major mission of medical facilities of the Department of Veterans Affairs in any law, other than this Act;

(2) any provision of title 38, United States Code; and

(3) the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

SEC. 8. REPORTS.—As part of each annual budget request for the Department of Veterans Affairs, the Secretary of Veterans Affairs shall transmit to the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives—

(1) a schedule of the realignment or major mission change actions to be carried out under this Act in the

fiscal year for which the request is made and an estimate of the total expenditures required and cost impact of each such realignment or major mission change and of the time period within which such cost impact would occur in each case, together with the Secretary's assessment of the environmental effects of such actions; and

(2) a description of the medical facilities, including those under construction and those planned for construction, to which functions are to be transferred as a result of such realignments or major mission changes together with the Secretary's assessment of the environmental effects of such transfers.

SEC. 9. FUNDING.—(a) There is hereby established on the books of the Treasury a separate fund that shall be available to the Secretary only to the extent or in such amounts as are provided for in appropriations Acts to carry out the purposes of this Act. No other funds shall be available for this purpose.

(b) The fund shall consist of—

(1) funds appropriated for the purpose of this Act;

(2) funds transferred to this fund from funds appropriated to the Department of Veterans Affairs for any purpose, except that such funds may be transferred only after the date on which the Secretary transmits

written notice of, and justification for, such transfer to the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives; and

(3) proceeds described in section 6(b)(2)(A).

(c)(1) The Secretary may use the funds in this fund only for the purposes described in section 6(a).

(2) When a decision is made to use any amounts in this fund to carry out a construction project under section 6(a)(1) and the cost of the project will exceed the maximum amount authorized by law for a minor construction project, the Secretary shall notify in writing the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives of the nature of, and justification for, the project and the amount of expenditures for such project.

(d) No later than sixty days after the end of each fiscal year in which the Secretary carries out activities under this Act, the Secretary shall transmit a report to the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives of the amount and nature of the deposits into, and the expenditures from, this fund during such fiscal year and of the amount and nature of other expenditures made pursuant to section 6(a) during such fiscal year.

(e) Unobligated funds which remain in this fund after the termination of the authority of the Secretary to carry out a

realignment or major mission change under this Act shall be transferred to the miscellaneous receipts account in the United States Treasury.

(f) No later than sixty days after the termination of the authority of the Secretary to carry out a realignment or major mission change under this Act, the Secretary shall transmit to the Committees on Veterans' Affairs and Appropriations of the Senate and House of Representatives a report containing an accounting of—

(1) all funds deposited into and expended from the fund or otherwise expended under this Act; and

(2) any amount remaining in this fund.

SEC. 10. CONGRESSIONAL CONSIDERATION OF COMMISSION REPORT.—(a) TERMS OF THE RESOLUTION.—For purposes of section 3(b), the term "joint resolution" means only a joint resolution which is introduced within three months of the transmittal of the statement and report by the Secretary of Veterans Affairs referred to in section 4(a), and—

(1) which does not have a preamble;

(2) the matter after the resolving clause of which is as follows: "That Congress disapproves the recommendations of the Commission on Medical Facility Realignment and Major Mission Change established by the Secretary of Veterans Affairs as submitted to the

Secretary of Veterans Affairs on ", the blank space being appropriately filled in; and

(3) the title of which is as follows: "A joint resolution disapproving the recommendations of the Commission on Medical Center Realignment and Major Mission Change".

(b) REFERRAL.—A resolution described in subsection (a) introduced in the House of Representatives shall be referred to the Committee on Veterans' Affairs of the House of Representatives. A resolution described in subsection (a) introduced in the Senate shall be referred to the Committee on Veterans' Affairs of the Senate.

(c) DISCHARGE.—If the Committee to which a resolution described in subsection (a) is referred has not reported such resolution (or an identical resolution) within three months of the transmittal of the statement and report by the Secretary of Veterans Affairs referred to in section 4(a), such committee shall be, as of that date, discharged from further consideration of such resolution, and such resolution shall be placed on the appropriate calendar of the House involved.

(d) CONSIDERATION.—(1) On or after the third day after the date on which the committee to which such a resolution is referred has reported, or has been discharged (under subsection (c)) from further consideration of, such a resolution, it is in order (even though a previous motion to the

same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the resolution (but only on the day after the calendar day on which Member announces to the House concerned the Member's intention to do so). All points of order against the resolution (and against consideration of the resolution) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the respective House shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the respective House until disposed of.

(2) Debate on the resolution and on all debatable motions and appeals in connection therewith shall be limited to not more than ten hours, which shall be divided equally between those favoring and those opposing the resolution. An amendment to the resolution is not in order. A motion further to limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other

business, or a motion to recommit the resolution is not in order. A motion to reconsider the vote by which the resolution is agreed to or disagreed to is not in order.

(3) Immediately following the conclusion of the debate on a resolution described in subsection (a) and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the resolution shall occur.

(4) Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a resolution described in subsection (a) shall be decided without debate.

(e) CONSIDERATION BY OTHER HOUSE.—(1) If, before the passage by one House of a resolution of that House described in subsection (a), that House receives from the other House a resolution described in subsection (a), then the following procedures shall apply:

(A) The resolution of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subparagraph (B)(ii).

(B) With respect to a resolution described in subsection (a) of the House receiving the resolution—

(i) the procedure in that House shall be the same as if no resolution had been received from the other House; but

(ii) the vote on final passage shall be on the resolution of the other House.

(2) Upon disposition of the resolution received from the other House, it shall no longer be in order to consider the resolution that originated in the receiving House.

(f) RULES OF THE SENATE AND HOUSE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 11. DEFINITIONS.—In this Act—

(1) the term "medical facility" has the same meaning as contained in section 601(4)(A) of title 38, United States Code;

(2) the term "major mission change" means any substantive change in clinical programs or patterns of delivery of medical care at a medical facility, or part thereof, under the jurisdiction of the Secretary; and

(3) the term "realignment" means any merging of the functions, activities, staff, or property of two or more medical facilities, or parts thereof, or any relocation of functions at or from any medical facility, or part thereof, under the jurisdiction of the Secretary.

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PREPARED STATEMENT OF HON. DENNIS DeCONCINI, U.S. SENATOR FROM THE STATE OF ARIZONA

Mr. Chairman, thank you for promptly scheduling this hearing regarding a most important issue of concern to the veterans in my home State of Arizona—comprehensive realignment of VA medical facilities. It took courage for Secretary Derwinski to raise this issue, and I commend him for his steadfast approach to this matter despite heavy criticism. I strongly agree that it is high time after almost 25 years for a comprehensive review of the quality and effectiveness of the VA medical care system.

The criticism made so far, however, should have been expected. Veterans are afraid that this is the beginning of the dismantling of the VA health-care system. The Reagan-Bush era of decremental budgeting provided ample fodder for leveling such attacks upon the present Administration on the issue of VA medical facilities realignment. I am glad to say that I believe that times have changed for the better. Veterans nationwide now have an advocate in the Cabinet who has proven himself to be a straight-shooter. I am certain that when Ed Derwinski says that none of the 172 hospitals the VA operates today will be closed as a result of this realignment report, he's dealing from the top of the deck.

I know the Secretary remembers well the meeting in my office early last year. I expressed my concern that certain inequities may exist in the allocation of scarce medical care dollars to the States with growing veteran populations.

I told Ed I believed the resource allocation methodology used by the Department may overemphasize utilization of medical services, and, therefore, overly rewards medical districts where veterans have learned to place too great a reliance upon the local VA facilities for primary medical care services. I stated then, and still believe, that in States like Arizona and Florida, where the veteran population is still growing, are penalized to some degree because the growth-related demand for services cannot be absorbed fast enough by the local VA medical care facilities.

I relayed Arizona veteran reports of crowded waiting rooms and appointment delays which I believe have caused lower utilization rates. In essence, the Sunbelt veteran has been taught that VA medical services are not readily available. Whereas many discouraged veterans have sought services elsewhere, many have no other recourse. My fear is that these less fortunate veterans are showing up later with aggravated health problems which result in expensive inpatient acute care costs. In sum, utilization occurs at a lower rate, and in turn, yields relatively fewer resources to States with growing veterans populations. Thus, interregional medical care budgeting may occur on the basis of use of medical care services more than budgeting based upon need for medical care resources.

In response to this concern, I received the Secretary's assurance that he would take a look into this matter and take corrective action if needed. I also requested that Ed make every effort to assure that Sunbelt areas are provided with the additional resources to service their substantial winter population as well as the permanent veteran population. The additional strain upon medical care services, especially the provision of pharmaceutical supplies, greatly exceeds the ability of our Sunbelt medical centers. In turn, that demand unduly limits the discretionary medical care options available to medical center directors. Thus, the permanent residents of Sunbelt communities may not be receiving the same array of services available to veterans residing elsewhere.

Last, I told him about the special needs of some rural veterans in northern Arizona, especially those on the Navajo Nation who live well over 6 hours from the nearest VA medical facility. Even worse, these same veterans must often travel another 2 to 4 hours to Phoenix or Tucson to be seen by a medical specialist.

I am pleased to say that I have seen some degree of progress on all these issues since Ed has taken office. First, as we all know, the Secretary began open and frank public discussions last July with Congress about the need for realignment to assure cost-effective quality health care. These discussions have culminated with the introduction of the legislation which is the subject of the hearing today.

We have also seen progress in the mobile health-care clinic program. Although the Administration did not share the enthusiasm Senator Mitchell, Senator Mikulski and I have for the mobile clinic program, I am pleased to hear that things are progressing well on the demonstrations for the Arizona and three other test sites. I believe the mobile clinics hold great promise for improving health-care services in areas which cannot support permanent medical care facilities. I hope to hear more details about the mobile clinic demonstrations during this hearing. Again, thank you Mr. Secretary and Tony for your extraordinary efforts to date to revive this Department and restore medical care funding to a level which ensures quality health

care. I know that you agree that we all have much more work to do and I hope that the cooperative effort we have all made to date continues uninterrupted.

Mr. Chairman, again thank you for your leadership and the hard work of your most able staff. I also commend you for your latest effort to secure a supplemental appropriations request for veterans medical care. I was pleased to cosign that letter to the President, and I assure you that I will do all I can to push a supplemental through the Appropriations Committee should we succeed in eliciting a supplemental request from the Administration.

PREPARED STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM THE STATE OF FLORIDA

Mr. Chairman, the Secretary often talks about how, in his travels, he has become increasingly aware of the discrepancies in availability of health care to American veterans.

I have heard the same stories, but I didn't have to travel around the country.

Hardly a day passes that my office does not hear a complaint about the availability of veterans health care in Florida.

There is a concept that Secretary Derwinski has supported—the concept of equity of access. A veteran's home residence should not determine his or her ability to access the VA health-care system.

As a member of this Committee, I have worked with staff at the VA over the last few years to collect pertinent data to determine the status of health-care availability.

However, the data available only reflects those who are successful in entering the health-care system. It does not account for those veterans who are victims of what has become known as "suppressed demand."

In a State with a largely disabled and aging veterans population, such as Florida, health-care services are not as readily accessible to non-service-connected veterans.

Florida veterans who are not category A are becoming pessimistic about the system. In many cases, they have simply given up trying to get the aid for which they are eligible. It is time to dispel veterans' doubts about the commitments of the VA and of Congress.

The VA health system must be overhauled to keep updated with the medical needs of the veterans' population without prejudice to home residence.

While I may disagree with the Secretary on some of his administrative plans, he is right on target with his call for a major review of the mission of VA medical facilities.

Such a Commission will help us evaluate the type of care the VA is providing and make the appropriate changes to meet the changing needs of veterans. This Commission can help up make wiser decisions about how to appropriately allocate the Federal dollars for veterans' health care.

I look forward to reviewing the results of this study and would be glad to assist the Secretary in his effort.

PREPARED STATEMENT OF HON. JAMES M. JEFFORDS, U.S. SENATOR FROM THE STATE OF VERMONT

Mr. Chairman, I, too, want to extend my welcome to the witnesses here today. The issue to which they will address, veterans health care, is an issue of immense importance. The VA provides care to over 1 million veterans ranging from inpatient care, nursing home care, outpatient care and domiciliary care.

Specifically, this issue is of considerable importance to the 55,000 veterans in the State of Vermont. Vermont, has only one medical care facility. It is located southern Vermont, northern Vermont, eastern and western Vermont—in other words for the whole of Vermont—as well as five counties in western and northern New Hampshire. Veterans living in Canaan or Alburg can travel as far as 130 miles, one way, for care.

The VA health facility in White River Junction, VT is, therefore, very important to Vermont and New Hampshire veterans. It is because Vermont has one hospital to care for 55,000 veterans that I approach the legislation before us today with some apprehension and caution.

In theory, I do not oppose the proposition of establishing a Commission to examine VA medical facilities and missions. I agree that demographics have changed and that the VA must alter it's mission to support the needs of an elderly population.

However, I believe we must proceed cautiously. New options and programs must be considered, which may not resort in closure.

For instance, the VA facility in Vermont has embarked on an innovative arrangement between the VA and six regional community mental health centers to provide outpatient mental health services to veterans. Under the program, called Veterans Integrated Community Care, or VICC, the VA takes full responsibility for providing outpatient services for veterans in the catchment area.

VICC clinicians play an important role in ensuring continuity of care within the VA system. They screen acutely ill veterans and explore all alternatives to inpatient care. If hospitalization is necessary, they provide the VA's inpatient staff with the patient's treatment records and important clinical information such as details about the patient's family problems. The VICC clinicians also work with the inpatient staff to develop comprehensive treatment goals that can be pursued after the patient's discharge.

The cost of the program is substantially less expensive, costing $14 to $20 a visit compared with $32 to $38 a visit for hospital-based outpatient care. The program, however, is critically linked to the VA hospital. VICC clinicians provide critical outpatient and preventive care, but they cannot substitute for the inpatient and full care provided by the VA hospital.

VICC provides support for the VA medical center, effectively and inexpensively and saves staff time, costs and enhances outreach. What it does not provide is the necessary full patient care that the medical facility provides.

It is programs such as VICC which we must encourage. These programs reduce costs and enhance outreach. They can save us from drastic measures such as hospital closure which could severely jeopardize access to health-care facilities for thousands of veterans.

Mr. Chairman, I look forward to the remarks of the witnesses before us today. I hope that the Committee will precede cautiously in its efforts to restructure the veterans health-care system. We must continue to move in a way that keeps the concerns of all veterans in mind, both rural and urban.

PREPARED STATEMENT OF HON. STROM THURMOND, U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Mr. Chairman, it is a pleasure to be here this morning for a continuation of our hearing we began last Wednesday on proposals which would consider the realignment and mission change of VA medical facilities. As mentioned last week, there has not been a comprehensive review of the distribution of health-care resources to veterans in over two decades. In that time, there have been population shifts, increases in the number of elderly veterans, major advances in medicine, and many other changes.

I want to again commend Secretary Derwinski, Deputy Secretary Tony Principi and all the others at the Department of Veterans Affairs for their initiative in this matter.

I also want to thank the various witnesses for returning to be with us, and for the insights which you will be sharing.

Again, Mr. Chairman, thank you for scheduling this hearing and I look forward to reviewing the testimony.

PREPARED STATEMENT OF HON. EDWARD J. DERWINSKI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, thank you for holding this hearing and providing me with the opportunity to report to you my initiative to establish a VA Commission on the Future Structure of Veterans Health Care. Accompanying me today are the Deputy Secretary, Mr. Anthony J. Principi; the Chief Medical Director, Dr. John A. Gronvall; Miss Marjorie Quandt, the Commission's Executive Director; and our Deputy General Counsel, Mr. Robert Coy. We look forward to participating in these discussions today.

VA Obligations, Commitments, Expectations

Mr. Chairman, the VA health-care system has many continuing responsibilities and obligations. First and foremost, we must provide America's eligible veterans a continuum of comprehensive, quality care and services. We are a primary source of education and training for practitioners. We sponsor and host research. We are re-

sponsible for providing emergency medical services in conjunction with declared national emergency or wartime contingency, and for sharing our health-care resources with our DOD partners to make maximum use of our Federal health-care dollars.

I have visited many of our medical facilities and I am impressed by what I have seen. But, we know the system and many of its component parts are strained when we are not properly structured to fulfill our missions.

It is imperative that the Department improve the structure, organization and delivery of VA health-care services. We must act now to dispel any doubts about our commitment to quality health care for eligible veterans, and to prepare for the future to meet their needs.

Of particular concern to me, Mr. Chairman, are the needs of aging veterans. For example, in Fiscal Year 1988, older veterans represented a substantial workload in VA medical centers, as follows:

Type of care	65 and older (percent)	Frail elderly—75 and older (percent)
Hospital	37	9
Outpatient	40	9
Nursing home	67	30
Domiciliary	13	3

The data for Fiscal Year 1988 show the elderly do not experience a significantly larger number of episodes of care compared to veterans under 65, but the length of stay per hospitalization episode of older veterans is much greater:

Category of eligibility	Average length of stay by age		
	65–74	75–84	85+
SC 10 percent plus	27	19	32
SC 10 percent minus	17	25	17
NSC w/pension	21	26	67
Former POW, WWI	73	90	170

Experience shows that among five outpatient clinical groups, veterans 65 or older have a higher cost per visit, and often a greater overall expense due to a higher visit rate. The exception is among those psychiatric patients with more than 25 visits per year. In this group the highest cost per case is seen in veterans 55–64 years of age. The example below shows costs of VA "high use rehabilitation" and "high use psychiatric" patients in Fiscal Year 1989:

Clinical group	Age	Visits per patient	Cost per patient
High rehabilitation	65–74	40	$1,569
High rehabilitation	75–84	40	1,669
High rehabilitation	85+	35	1,319
High psychiatric	55–64	43	2,000
High psychiatric	65–74	39	1,950
High psychiatric	75–84	37	1,848
High psychiatric	85+	41	1,429

Mr. Chairman, a recent study of ours projects continued growth in the number of elderly veterans in the 1990s. The number of veterans 65 years of age and older is expected to increase from the 1988 total of 6.7 million to a peak of 9 million in 1999, a 34 percent increase. Veterans 75 and older will grow from today's 1.4 million to 2.6 million in 1995, and then more than triple in size over the next 15 years to 4.4 million. By the year 2010, veterans 65 and older will comprise 40 percent of the eligible veteran population, as compared to 26 percent in 1989. This age shift, if trans-

lated to utilization at current rates, could bring dramatic change to the patient mix we will see in VA health care in the future. For example, we expect that by the year 2010, 35 percent of VA hospital patients will be at least 75 years of age and 60 percent will be over 65. The health needs of persons in these older age cohorts for inpatient, outpatient, nursing home and community-based care could require major adjustments to the system to meet their needs. Thus, we need to explore a number of avenues to meet the challenge of caring for eligible veterans, including aging veterans, by providing cost effective, high quality and appropriate VA care.

Mr. Chairman, another obligation stems from our facilities' value to their communities across the country. Before this Committee last November 15, I indicated I was impressed with our VA medical centers' service to isolated and rural areas. Having personally visited several of them since my appointment, I reiterate my support for maintaining a VA presence in these rural communities. They deserve and will receive special consideration.

Necessity of Change

Past internal actions to restructure VA programs or facility missions were taken in isolation. The Medical District Initiated Planning Program (MEDIPP)—the most recent internal planning system of the Veterans Health Services and Research Administration—has been able to move the system toward greater balance and equity. Much has changed since many of these facilities were built and since the VA system was formed. Medicine has changed. We've made great treatment advances, but have also been plagued by new problems and diseases. Medical practice has also evolved from hospital-based care to greater emphasis on a continuum from outpatient to extended care. Significantly, population patterns and the average age of our beneficiaries have also changed. But the VA system has not changed quickly enough to keep pace. We now need an independent analysis to help us integrate the latest innovations in health-care delivery in order to meet the needs of the eligible veteran population.

Commission Rationale

Despite these enormous changes in American medicine and veteran population demography since the VA system was formed, the system, and specifically its many health-care facilities, have not been subjected to a broad, thoroughgoing review in 25 years. As a consequence, we must ask if we have the best mix of missions, services and programs in our medical facilities to achieve the most effective, efficient, and appropriate distribution of health-care resources to care for our eligible veteran population. I believe the time has come for a fresh examination of the VA by an outside group of experts: a VA Commission on the Future Structure of Veterans Health Care.

In establishing this special Commission, our primary goal is to assure that VA medical facilities provide the best care possible while affording eligible veterans expected to use the system equitable access to this care, nationwide. We will ask the Commission to review VA health-care delivery processes, standards, structures, and outcomes, as well as staffing and technological requirements. We want the Commission to examine the geographic distribution of expected patients and VA services, the match between them, and the types and levels of resources required to maximize these veterans' access to care. In addition, we will charge the Commission to study and consider the socioeconomic impact of its recommendations on the medical facility's community. These considerations would be taken into account as the Commission formulates its recommendations to me.

To summarize, the Commission's primary duties are to examine the current VA system's configuration and quality of facilities and services, and in consideration of the probable future medical care needs of eligible veterans who are expected to use the system, determine whether changes in mission and programs (at individual facilities) may be necessary.

Mr. Chairman, concern has been raised by some veterans service organizations about a perception that this Commission may be intended for purposes other than to help us make a better VA which will do a better job for veterans. I very much want to dispel that notion. For the last 4 years, four veterans service organizations—AMVETS, DAV, PVA, and VFW—have jointly produced an "independent" budget for congressional consideration of needs in VA medical care. I would like to offer the Committee today some of the words from those budgets, . . . by veterans, for veterans . . .:

> ". . . There is an alarming lag in revamping the VA modalities of medical care to meet these changing and growing needs. Especially apparent is the

delay in acquiring, by conversion and construction, sufficient nursing home beds to meet the demand of the coming decade. . . ."

". . . There should be sufficient quantities and balance of the various types and levels of medical care available to VA patients to promote maximum efficiency in the use of resources in the VA continuum of care. . . ."

". . . Increased commitment to a realignment of VA health-care delivery is needed. The balance among modalities needs to shift in response to the growing impact of the needs of the aging veteran group. Realignment must also take place in recognition of the demographic truth that a major population shift to the "Sun Belt" continues to take place. . . ." ("Meeting the Challenge: An Independent Health Care Budget for Veterans, January 1987")

* * *

". . . VA facilities should be situated and staffed to serve veterans in the areas of the country where veterans live. For both health-care facilities and regional offices, this means a geographic realignment paralleling the major population shift of veterans to the Sun Belt. This shift requires a reallocation of staffing and may necessitate new facilities as well as expansion of existing ones. . . ."

". . . The Veterans' Administration should intensify its efforts to develop, demonstrate, and implement cost effective noninstitutional health-care alternatives [and] . . . delivery systems and should continue its leadership role. Increased commitment to a realignment of VA health-care delivery modes is needed. . . ."

". . . The balance among modalities needs to shift in response to the growing impact of the needs of the aging veteran group. In particular, the VA must move swiftly and energetically to convert hospital capacity to meet nursing home care, other extended care, and ambulatory care needs. . . ." ("Meeting the Challenge: To Keep the Promise. An Independent Budget by Veterans for Veterans' Programs. Fiscal Year 1989")

* * *

". . . The VA should be persuaded to step up the realignment of its health-care facilities to better accommodate the long-term care impact of the aging veteran. This especially includes a more rapid conversion of excess hospital beds to nursing home units and targeted increases in noninstitutional extended care programs. . . ."

". . . The VA has been a leader in vertically integrated health-care delivery systems and this role should be enhanced by demonstrating increased commitment to a realignment of the VA health-care system in response to needs of veterans. . . ." ("The Need is Now, An Independent Budget by Veterans for Veterans' Programs, Fiscal Year 1990")

* * *

". . . VA should site and staff its facilities to serve veterans in areas of the country having the greatest demographic need for veterans' services. . . ."

". . . [VA should] [r]e-evaluate each medical center's mission in the system, to reduce unnecessary duplication of services and limit program expansion. . . ." ("The Price of Peace, The Nation's Obligation: Correcting Budget Priorities for Veterans, Fiscal Year 1991, Independent Budget for Veterans Affairs")

* * *

Mr. Chairman, in paying attention to this excellent advice from our major national veterans organizations, I believe I am doing something good for the VA system and for its patients. Deputy Secretary Principi and I, as well as the other members of our management team, embrace all these same ideas—ideas and themes recommended again and again by four prominent veterans organizations.

During our March 14 hearing before the House Subcommittee on Hospitals and Health Care of the Veterans' Affairs Committee, a question was raised that I wish to further address this morning, Mr. Chairman. It goes to the heart of some people's concerns about the purpose of this Commission. I want this independent Commission to be intellectually, technically and professionally free to come in with whatever recommendations its wisdom and common sense can bring to us which will improve the VA health-care system. Because this is an "administrative" Commission, I am in a more flexible position to consider its recommendations in respect to implementation. I am confident that Congress, as a policy making body, will join me in carefully examining the Commission's recommendations. Together, in consideration of the Commission's "blueprint," I believe we can develop a strategic plan to meet

veterans' future health and medical care needs, and do it in a way that is beneficial to all concerned.

Mr. Chairman, to aid the Committee's understanding of my rationale for establishing this special review of VA health care, let me anticipate some of your questions and give you a more specific capsule on various aspects of our plan:

The Mission of the Commission

The Commission on the Future Structure of Veterans Health Care will be a group of distinguished individuals with backgrounds in such fields as medical care, health science, health policy and economics, education and research, and veterans issues. The Commission will review many aspects of VA health care and recommend means to achieve quality health care effectively and efficiently for an eligible and aging veteran population. We will ask the Commission to review the missions and programs of every VA medical facility to ascertain whether programmatic improvements or enhancements can be realized through facility realignments or major mission changes. And, the Commission will assess the needs of eligible veterans, taking special note of the needs of aging veterans, with a focus on the years 2000–2010. The Commission will be appointed in consultation with the Deputy Secretary and other VA officials. After a thorough review of the total health-care program, the Commission will submit a final report for executive consideration and careful implementation.

Commission Memeers

The Commission's charter provides for no fewer than 9 and no more than 15 members reflecting the many parties interested in VA care, such as our patients, hospital management, medical practice, geriatrics, nursing, academic medicine and research, health policy and economics, and multisystem health-care management.

I will appoint a balanced Commission, based on advice from a number of sources, including this Committee and other concerned congressional committees. Also, congressionally chartered veterans' service organizations have been asked to suggest persons they believe would be qualified Commission members. The VA Chief Medical Director and other VA officials will suggest names of potential members. We will seek individuals knowledgeable about the health-care system of the Department of Defense and the health-care benefits administered by the Department of Health and Human Services. Individuals with broad experience in Government service and others from private enterprise will also be included. Other members will be persons from among those clinical care, nursing, medical research and educational activities affected by the veterans' medical care system, or persons with experience in management of health services, medical research, health economics or health policy.

Our goal is to bring the best minds in health care and medical administration—in the public and private sectors—to bear on our interests and those of the public. Medical care is highly complex and dynamic, and to evaluate it effectively a broad range of viewpoints is essential. The Commission and its staff will seek to exchange information and interact with the Pepper Commission, the Social Security Commission, the HHS Agency for Health Care Policy and Research, and the national health policy work group functioning within the Domestic Policy Council.

Secretary's Guidance to the Commission

I will ask the Commission to conduct its review with a focus on the years 2000–2010. Among a number of matters, I want the Commission to consider possible changes which may have occurred by then. More specifically, the Commission will be asked to consider the following in its planning:

—The needs of service-connected, aging, and other veterans expected to use VA care;

—The most appropriate kinds and levels of cost effective care to eligible veterans;

—The existence of new health-care professions and the greater availability of methods to recruit and retain existing professionals;

—Shifts from inpatient status to the alternatives to traditional bed care for some long-term, chronic care, and terminally ill patients;

—Increased opportunities to improve service delivery and cost effectiveness through sharing and developing innovative health-care delivery arrangements with DoD facilities and with the local community; and

—Changes which may occur in medical education and the possible impact of these and other changes on VA-academic affiliations.

We will also ask the Commission to report the costs and/or savings associated with each of its recommendations.

The Commission Process

The Commission will meet approximately bimonthly and review detailed information compiled by its staff on each VA medical facility. Such data will include information on workload, populations served, medical care indicators, physical plant and equipment, and health-care environment. It will hold open meetings in Washington and elsewhere. The Commission will also visit facilities which, based on the Commission's research and inquiry, may become candidates for possible mission or program changes. The local community will be consulted along with private sector health-care providers, veterans service organizations, and personnel of individual facilities.

Site Visits

Specific facility site visits will be dictated by criteria established by the Commission, in consonance with my guidance. These could relate to matters concerning quality, recruitment and retention of key clinical staff, the recorded cost of care, efficiency and productivity, workloads, centers of excellence, apparent duplications of services or programs, or other pertinent variables and facts. Impacts of any proposed changes on the facility, its patients and staff, and the community at large are best assessed by in-person visits by the Commission and its staff. Therefore, the Commission will not recommend a major change at any VA facility without first having visited it. Facilities will be visited to seek information and clarifications, confirm findings from a number of data bases and ascertain if alternatives are viable and could be effectively and economically achieved.

The Commission's Relationship With VA and Other Officials

The Commission Chairman, and other members as necessary, will meet with me in conjunction with Commission meetings and periodically to provide progress reports and to seek clarification of policy questions which may arise.

The Chief Medical Director will be asked to appear before the Commission at its initial meeting to discuss the VA health-care system and make further appearances, based on the Commission's needs for information or advice or the CMD's wish to communicate with the Commission. The CMD and Veterans Health Services and Research Administration (VHS&RA) offices, as well as the medical facilities themselves, are seen as an invaluable and continuing resource to the Commission throughout its operation.

Opportunities to Provide Views

Top VA managers in Central Office will receive periodic briefings about Commission activity. This would include the Deputy Secretary, the Chief Medical Director and other concerned VA officials. These briefings may be for policy purposes or to impart information. Field personnel will be utilized in geographically dispersed hearings and as resources during specific facility site visits. Interested parties, such as congressional oversight Committees and VSOs, will receive reports on the Commission's progress. Members of Congress and VSO representatives will be asked to appear before the Commission when it meets at specified sites throughout the country, for example, in Chicago, Boston or Los Angeles. As a chartered Federal Advisory Committee, the Commission's meetings normally will be open to the public.

Initiation of Commission Work

A staff of nine FTEE are developing initial planning for the Commission. A charter has been approved and notice of the Commission's establishment will be published very soon in the Federal Register. Office space has been obtained and we are in the process of establishing the office and interviewing prospective staff members. We hope to appoint Commission members within the next month, and we anticipate the Commission will hold its first meeting in early May 1990.

Commission Staff Members

We will assemble a staff of about 30 FTEE to support the Commission. Staff are physicians, nurses, health planners, quality assessment specialists, and other professionals. Staff will be chosen from a variety of VACO offices and VHS&RA field fa-

cilities. Clinical specialists will be selected from the field for expertise in medicine, nursing and quality assessment. Staff from Central Office, and two FTEE on loan from DoD and DHHS will provide expertise in planning, epidemiology, demography, real estate, construction, engineering, and health services research. Staff members must be willing to accept a 12–18 month detail to this time-limited project, work long hours, and travel.

Staff Functions

The Commission staff will prepare orientation materials for the Commission members, provide staff support for subcommittee and full Commission meetings in Washington and throughout the country, develop useful data bases and analyze those data, examine all issues thoroughly, and provide information to VA officials, Congress, and to the public in general. The staff will prepare a proceedings of the Commission as well as assist the Commission in making its final report to me.

Data will be gathered for the Commission from existing VHS&RA and VA files: patient treatment, fee-basis and contract care, outpatient files, DHCP records, fiscal and accounting records, MEDIPRO summary records, special surveys, veterans service organization site visit reports, GAO and IG reports, and quality assessment records such as JCAHO reports. Data will be analyzed by Commission staff and by consultants hired for this specific purpose. Also, some original data collection may become necessary, but this will be kept to a minimum.

Target Date for Completion of Report

If the Commission begins work in April or May 1990, it is planned that the report will be presented to me in late summer 1991. The latest deadline for the Commission's report, should unforeseen events occur, is October 1, 1991.

Reporting

The proceedings of the Commission and major position papers will be available for review by interested parties, and these may be published as well. I intend to provide the Commission's final report to Congress and other interested parties. Also, as a Government publication, produced under the Federal Advisory Committee Act, the Commission's final report will be available to the general public.

Consideration of Commission Recommendations

The recommendations of the Commission and its report will be submitted to me. These will be reviewed by the Deputy Secretary, Chief Medical Director and other concerned VA officials. After consulting with key staff and officials and selecting strategic options, I will develop implementation strategies through the normal planning and budget processes.

Cost of Commission

It is anticipated the total cost of the Commission, including salaries of employees, will be $4.3 million. We anticipate making only one new hire for the Commission staff (a technical writer).

Legislative Proposals

In your letter of March 8, Mr. Chairman, you indicated one of the purposes of today's hearing would be to discuss the two legislative proposals currently pending before the Senate, S. 1332 and S. 1398. Last year, Senator Murkowski offered S. 1332, and I submitted the Administration's proposal, which you and Senator Murkowski introduced as S. 1398. A similar measure is pending in the House of Representatives. These two very similar Senate bills sought congressional recognition of the need for a special review of VA facilities, in order to develop a strategic plan for veterans' medical care for the next century. The most striking difference between these bills and the establishment of a Commission administratively concerns the matter of implementation. The legislation would have provided a relatively streamlined mechanism for implementing the Commission's recommendations as a "package." I understand the concerns which have surrounded that vehicle. The administrative approach which we have taken will by its nature give the Congress a full opportunity for review.

Mr. Chairman, the earlier legislative proposals have been overtaken by events. This year, should Congress in its wisdom enact a measure to underwrite this initia-

tive, I would not object; however, the Commission I am appointing shortly will begin its work, and I feel confident it can be effective and will produce a meaningful report even in the absence of a specific statutory platform. I hope you agree with me on this point, as I am certain the Chairman of the House Veterans' Affairs Committee holds this view.

SUMMARY

In summary, Mr. Chairman, we must conceive a path for our system—a strategic path, if you will—that will empower VA field facilities and the VA management structure to evolve practically, to address eligible veterans' needs as these are presented, and not hold off needed mission and program changes to some ill-defined future time. I want this Commission to help map out this VA strategic path.

The establishment of this independent Commission on the Future Structure of Veterans Health Care is in the public interest. It is critically important that we keep a singular focus on maintaining a comprehensive continuum of quality care in VA facilities, structured to meet the health and medical needs of our eligible veteran patient population, but recognizing the constraints and choices of Federal health-care spending. I am certain the Commission approach will give me—and future Secretaries—a set of executive and planning options that otherwise would be unavailable.

Mr. Chairman, may staff and I will be pleased to answer your and other Committee members' questions. I thank you again for allowing me this opportunity to discuss my concepts for the VA Commission on the Future Structure of Veterans Health Care.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the Committee, good morning. I am Dr. David Korn, Vice President and Dean of the Stanford University School of Medicine. On behalf of the Association of American Medical Colleges (AAMC), I appreciate the opportunity to testify today about the proposals to review the mission of the Department of Veterans Affairs (VA) health-care system.

The AAMC serves as the national voice for the country's 127 medical schools, 92 professional academic societies, and 420 major teaching hospitals, including over 70 VA medical centers. Currently, 139 VA medical facilities are affiliated with 103 medical schools. Each year more than 30,000 medical residents and 22,000 medical students receive a portion of their training in the VA. The AAMC is not only closely involved with the VA, but also appreciates and understands the complex and comprehensive nature of the Veterans Health Services and Research Administration (VHS&RA).

The AAMC supports proposals to review the VA's current structure with the aim of improving the coherence of the system and insuring that the current and future needs of veterans can be met. The AAMC looks forward to working with Congress, the Administration, veterans service organizations, and other interested parties toward this mutual goal. I am pleased to note that the Secretary has asked for input from a variety of sources, including medical educators, and that the Commission's deliberations will be conducted in an open and accessible process.

We agree with Secretary Derwinski that the VA's primary focus must be on the best way to meet veterans' health-care needs. We also agree with the overall charge to the Commission, as described by Secretary Derwinski:

> The Commission of the Future Structure of Veterans Health Care will be a group of distinguished individuals with backgrounds in such fields as medical care, health science, health policy and economics, education and research, and veterans issues. The Commission will review many aspects of VA health care and recommend means to achieve quality health care effectively and efficiently for an eligible and aging veteran population. We will ask the Commission to review the missions and programs of every VA medical facility to ascertain whether programmatic improvements or enhancements can be realized through facility realignments or major mission changes.

I am also pleased to note that the Secretary specifically asked the Commission to consider, "Changes which may occur in medical education and the possible impact of these and other changes on VA-academic affiliations," among the six points for review.

Affiliations are symbiotic arrangements that benefit both the VA and medical schools. Affiliations between VA medical centers and medical schools, or Dean's

Committee affiliations, greatly enrich the patient care environment of VA medical centers and enhance the educational and research programs of medical schools. Medical education remains to this day, in part, an apprenticeship, and effective education requires access to a diverse mix of patients who come to an academic medical center with the expectation that they will receive the highest quality of comprehensive and compassionate medical care. In return for their participation in medical education, VA medical centers, like other teaching hospitals affiliated with medical schools, gain access to talented faculty and state-of-the-art treatment. When the affiliation policy was first articulated in 1946 under the direction of General Omar Bradley, the (then) Veterans' Administration was explicit about its aims. "Policy Memorandum 2" read, "The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of care than could be given him with a wholly full-time medical service." In short, affiliations improve immeasurably the quality of care by enabling the recruitment and retention of talented professionals and by creating an intellectually challenging and dynamic environment that shapes the general ambience of the VA medical center. Both partners in the affiliation share a common goal, since a quality health-care environment is not only good for veterans, it is essential for high quality medical education.

Dean's Committee affiliations are not static, but evolve as the health-care system, and the corresponding needs of veterans and medical education, change. Among many other changes in medicine, there are two distinct factors that I will highlight because of their relevance to VHS&RA—namely, the practice of medicine has shifted toward ambulatory settings and the population is aging. Medical schools are attempting to adapt their educational programs to these developments. For this reason, the specialized VA treatment and research programs, such as the Geriatric Research, Education, and Clinical Care Center (GRECC) at the Palo Alto VAMC, are equally important to veterans and to our training programs. The GRECC conducts weekly clinics in geriatric medicine and co-administers the Hospital-Based Home Care program, the Outpatient Mental Hygiene Clinic, and the Older Adult and Family Research and Resource Center. This is an excellent example of how the future needs of medical education and the veterans health-care system are consonant and how the mutual goals of the VA and medical schools can be met simultaneously.

Affiliations can be also be effective mechanisms for facilitating the development of regional health-care networks that are based upon the VA medical center. The Stanford University School of Medicine has been affiliated with the Palo Alto VAMC since the early 1960's; in the past year we entered into a new affiliation with the Livermore VAMC. We are greatly enthused about this new affiliation, not only for the opportunities it presents in ambulatory care, extended care, rehabilitation, and geriatrics, which are key components of the "future mix" of medical care, but also for the chance to extend and solidify a nascent relationship between the Livermore VAMC and the tertiary care program capacity of the Palo Alto Center. Sophisticated clinical programs made possible through such affiliations can be used as the foundation of efficient "hub-and-spoke" networks between VA facilities of differing complexity to deliver convenient and cost-effective care to veterans in a broad geographic area. The Commission can serve a useful purpose in reviewing exemplary affiliation arrangements and recommending ways other affiliations might be developed or improved to meet the health-care needs of an aging veteran population in the coming decades.

In preparing my remarks for this hearing, I was aware of some letters to Members of Congress that were written last year by my colleagues at other medical schools. The tone of those letters is clearly consistent; deans across the country explained that they are troubled by resource inadequacies that are producing a noticeable decline in quality in VA medical centers. As a result, the VA is becoming a less suitable environment for medical education and training. I understand that education and training are medical school matters, not the VA's, but our joint concern is quality. It is my hope that the Commission will attend closely to the resource problems identified by our medical schools. Foremost among them is the recurring shortfall in the VA medical care appropriation, which Congress is called upon to correct each year. The funding shortfalls have a direct impact on patient care. I also believe that the Commission should carefully review whether the VA's Resource Allocation Methodology (RAM) properly recognizes the resource intensity of medical centers treating higher acuity patients, or adequately responds to resource wages in the ambulatory health-care setting.

Once again, the AAMC recognizes the primacy of the VA's purpose as providing quality health care to eligible veterans. Moreover, we share that same central goal because it is good for veterans and because it is good for students.

In the interest of accomplishing what is best for the overall system, the AAMC pledges to review without bias the determinations of the Commission. Our support will not be deterred by the presence of certain recommendations that may adversely affect some of our individual members. I think the AAMC has demonstrated good faith and a solid record in this regard; although, I would add that much like members of Congress whose districts may be effected by the Commission's recommendations, some of the individual institutions that would be affected may speak out on their own to oppose prescribed changes. This type of reaction must be expected when addressing sensitive and highly political issues.

The results of the 1986 VA internal review of the cardiac surgery program reveal a good example of how difficult this process can be. We can recall the pitfalls and bruises that accompanied implementing the series of recommendations made by that working group. I am confident that this Committee also remembers that episode. My purpose in bringing up this example is to remind the Committee that the AAMC did not resist the working group's recommendations. In fact, the AAMC remained neutral, despite the fact that certain of its member institutions actively opposed some of the proposed changes. The analogy also serves as a reminder of a process that could very likely be repeated following the mission change Commission's recommendations. All of those involved in the process as well as those watching the process will face difficult decisions. Again, the AAMC pledges that it will work with its constituents, the VA Central Office, Congress, veterans' service organizations, and other interested parties to help to resolve difficult decisions.

Within our framework of general support of the Secretary's proposal, I would be negligent if I failed to mention a few specific concerns and issues. First, the AAMC's ability to offer support and cooperation would be enhanced if the academic community were adequately represented on the Commission. I hope this will be the case, as the academic community can add important perspective and thoughtful consideration to an overall review of the system. In addition, as I noted earlier, one of the six points Secretary Derwinski will ask the Commission to evaluate involves affiliations and the possible impact of the Commission's recommendations on medical education. To address this issue adequately, the Commission would benefit from the full participation of medical school representatives.

Second, I would suggest that the Commission's recommendations be treated as an approach, or a set of objectives to be reached over time, so that we will avoid abrupt changes that could cause short-term harm. We should also be mindful of and willing to accept that some of the proposed changes may involve initial financial costs.

Finally, I understand that Secretary Derwinski has emphasized that he does not intend to downsize or dismantle the VA health-care network, rather the Commission will be asked to do some rearranging, as determined to be appropriate. While I support this approach, I would hope the Commission will be at liberty to recommend where additional support is needed, as well as whether additional support is needed overall. In other words, I believe that the Secretary should be equally committed to accepting recommendations that might require increased resources to improve the system through realignment and enhancement.

Again, thank you for the opportunity to share my views with you. I will be happy to answer any questions or expand on my remarks.

PREPARED STATEMENT OF DR. WILLIAM T. BUTLER, CHAIRMAN, SPECIAL MEDICAL ADVISORY GROUP, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and members of the Committee, I am Dr. William T. Butler, President of Baylor College of Medicine in Houston. I also serve as Chairman of the Department of Veterans Affairs' Special Medical Advisory Group (SMAG), which was mandated by the Congress in 1946 to advise the Congress, the Secretary, and the Chief Medical Director on the medical care and treatment of veterans.

I appreciate the opportunity to present my views in support of Secretary Derwinski's initiative to establish a VA Commission on the Future Structure of Veterans Health Care.

The Veterans Affairs' Health System is clearly a national resource and holds a respected and unique position in the pluralistic health-care effort of our country. For the record, I would like to quote from a resolution adopted by the SMAG and transmitted to the Secretary and to Congress recently after a 2-year study of the VA System:

> "The Special Medical Advisory Group reiterates and reconfirms its wholehearted endorsement of the existing VA medical health-care system; a federally financed system of care dedicated to America's veterans. The VA system is a

prudent, stable, dependable national resource. It provides health care for veterans who served their country. It augments American medicine through its continued achievements in clinical, educational and research endeavors."

The role of the VA Health Care System has undergone many changes over the years, but I always refer back to the quote by Abraham Lincoln that is on the outside of the VA Central Office here in Washington which reads: "To care for him who shall have borne the battle and for his widow and his orphan."

That statement is central to the existence of the VA Health Care System. But within that philosophical context, the VA Health Care System also is becoming, to an increasing extent, a care system for the medically indigent veterans as well as those with service-connected problems.

We are all aware of the stress that is now on the indigent health-care systems within our Nation's communities. These systems are already overburdened and underfinanced. What would happen to our Nation's veterans if their care were no longer provided by the VA? It is clear that our local communities simply do not have the resources to provide the standard of care which our veterans deserve and to which they have become accustomed.

The quality of patient care in the VA System is to a significant degree due to strong affiliations with our Nation's medical schools. Through academic affiliations, VA medical centers attract young, vibrant physicians who want to practice medicine in an environment where medical knowledge is at the leading edge of discovery. I hope the Commission will recommend new ways to enhance the affiliations in improving the quality of care of veterans.

Another role of the VA hospital system that must be recognized is its strategic importance as a back-up to the Department of Defense in case of a national emergency. Even at this time of welcome demilitarization amid an atmosphere of growing world peace, we must not create an inability to meet a national medical crisis should it occur, as a result either of military action or natural disaster.

Having made these points, I also would like to say that during the past 8 years as a member, and for 5 years as Chairman, of the Special Medical Advisory Group, I have been an unwilling witness to gradual changes in this country's Veterans Health Care System. These changes have been forced upon the System and have eroded its effectiveness.

Few of these changes have resulted from careful planning by the Administration, nor have they been based on need and then approved by the Congress. These changes have resulted in a System which, I believe, is now strained and out-of-balance.

A thorough review such as that proposed by the Secretary is needed so the VA Health Care System can be structured to carry out its mission of providing America's eligible veterans a continuum of comprehensive, quality care and services.

The past two decades have seen enormous advances in American medicine and dramatic shifts in the veteran population. Without a mandate for change and with increasingly marginal funding over the past few years, the Department has, in my opinion, done an excellent job in reacting to change by reallocation of resources, and at the same time has continued to provide quality health care to eligible veterans.

On the other hand, we are now hearing of instances where the quality of this care may be compromised by inadequate staffing and resources. I believe the System's ability to maintain quality has now reached its limits.

New demands challenge the Commission's planning for the future. At SMAG's most recent meeting in December, 1989, we discussed a comprehensive study on how the VA should prepare itself to care for the aging veteran population. The concern is real. By the year 2010, 35 percent of VA hospital patients will be at least 75 years old and 60 percent will be over 65. This aging factor will bring dramatic change to the patient mix expected in VA health care in the future. It also will place increasing demands on the System for extended care. It is clear that the health needs of persons in these older age categories will require major adjustments in the System to meet inpatient, outpatient, nursing home, and community-based needs.

I would point out that the proposed VA Commission may well find that the indicated adjustments in the VA Health System require a greater, rather than a lesser, total commitment of national resources. I hope we all are able to look objectively at the facts and conclusions of the Commission's study and make recommendations that are in the best interest of our Nation's veterans, and, if necessary, find additional resources to implement them. I am also fully supportive of instituting cost-saving measures when clearly indicated. Sometimes such recommendations can be painful.

Several years ago, there was a concern within the VA Health Care System about cardiac surgery and the need to focus these services in a more limited number of

hospitals where they truly could be of high quality and cost effective. A plan was developed. SMAG looked at the plan very carefully with the Chief Medical Director and supported the VA in closing down cardiac surgery programs at selected hospitals. It was somewhat unpleasant, but when one looked at the broader picture of the quality and the cost effectiveness of cardiac surgery, it simply was not reasonable to maintain cardiac surgery in certain places.

Whether the Commission's findings indicate a need for expansion or reduction in facilities, or for more cooperative arrangements with existing health providers in both the public and private sectors, I am in agreement with the objectives and scope of the proposed charter for the Commission.

I think the study is central to the whole issue of integrity of the VA System.

I applaud Secretary Derwinski for moving quickly to assure that VA medical facilities during the foreseeable future provide the best possible care while at the same time ensuring eligible veterans equitable access to that care.

Thank you for allowing me to testify before the Committee. I will be glad to answer any questions.

PREPARED STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and members of the Committee, on behalf of the 2.8 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary I wish to thank you for having invited the VFW to participate in today's important hearing. The VFW is deeply concerned that the VA health-care system be fully enabled to provide for the health-care needs of this Nation's veterans.

The VFW has long pointed out that the rapidly changing nature of the veteran population bears careful watching and evaluation by VA health-care planners. VA must prepare to properly attend to the rapidly evolving needs of our aging veteran population. We commend you for conducting this hearing.

Mr. Chairman, in your letter of invitation, you asked for comments on three proposals. S. 1332, a bill introduced by Senator Murkowski which would provide for realignment and possible mission changes of medical facilities of the Department of Veterans Affairs; S. 1398, a bill introduced by you at the request of the VA to also achieve a realignment or mission change of VA medical facilities; and, the Commission on the Future Structure of VA Health Care which the Secretary of Veterans Affairs has established administratively. Inasmuch as the VA has already established a Commission the advancement of legislation to establish a Commission is, in our opinion, unnecessary at this time, the VFW does not believe a legislative approach is warranted and, therefore, does not support the enactment of the two bills before us today. At this time, I would like to address what we perceive to be the role of the Secretary's Commission and how it may impact on our Nation's veterans.

Even though the entire American population is advancing in years, the pace is much more rapid among veterans. Veterans 65 and older already make up more than a quarter of the veteran population and by the year 2000 they will comprise over one-third of the veteran population. This escalation will continue up until 2010 by which time veterans over 65 will number more than 12 million.

In view of the health problems associated with advancing years the VA health-care system must now prepare to meet steadily greater, increasingly diversified and more costly demand for health-care. This is in keeping with the VA medical system's primary responsibility to provide this Nation's aging veterans with the full continuum of care that they have earned in the service of their Nation.

Of course, within this formidable context, the Congress and the Administration must also ensure that adequate funding is provided to allow the VA to meet its mandated responsibility. It is only in this way that VA will be able to provide health-care which is commensurate with need. Further, VA, the Congress, in fact, all of us must keep clearly in mind that the nature of health-care need is changing.

In this regard, the Secretary of Veterans Affairs is exercising his authority to establish a Commission on Future Structure of Veterans Health Care. This Commission is to concern itself with, among other areas, human resource utilization, means of accurately assessing and then providing for need, and facility mission. It is important to note at this juncture it is our understanding that this Commission is not to be confused with the VA mission commission called for by the GAO, which is to examine the downsizing of the VA medical system. We have been assured that this is a completely different undertaking and its objective is to devise means to improve the VA health-care system and not diminish it in either size or scope. In a word, the

Secretary's Commission, as described, is being tasked with providing insight into how VA is to contend with the rapidly changing health-care needs of America's veterans as we move into the 21st century.

The VFW supports the ostensible reason for establishing this Commission, in fact, we have long argued that the VA health-care system should invest more time and energy in planning for the future. On the other hand, we are deeply concerned that this Commission be strongly oriented toward finding ways of providing veterans with the full continuum of health care that is their due.

All too often in the past, when there was talk of reexamining the VA's mission, reducing services was the hidden agenda. Experience has taught us to be very wary whenever the VA health-care system's mission is a topic of discussion on Capitol Hill. We have seen that terms such as "mission realignment," "consolidation" and "management efficiencies" are often actually OMB precipitated euphemisms for closing VA hospitals and generally reducing services to veterans. These past attempts to surreptitiously reduce rather than refine the VA health-care system should serve as a warning to all of us now to proceed with great caution.

Even so, we have seen that Secretary Derwinski may make quite a capable veteran's advocate. So we will not now oppose the formation of this VA health-care Commission and only here speak to those issues which we believe will render this undertaking as beneficial as possible.

Our first point is that the Secretary's Commission on Future Structure of Veterans health-care should assume the form of an advisory commission. That is, we believe its actions and deliberations should be constantly open to public scrutiny and that concerned non-VA entities, with special emphasis on veterans service organization oversight, should play an integral role in the Commission's operation. We view VFW and VSO involvement as being paramount to the successful and beneficial operation of this veteran's health-care oriented Commission.

In the VFW's opinion, one of the greatest obstacles in the path of VA health-care planners today is uncertainty with respect to the provision of requisite funding. Simply put, VA does not know from year to year whether it will be provided with sufficient funding to cover the health care mandated under current law.

Obviously this adversely affects veterans inasmuch as requisite health-care dollars are just not always at the right place at the right time. Accordingly, the VFW has resolved in a current national resolution that legislation be enacted to expand the meaning of the term "entitlement" so as to clearly establish a legal obligation to provide sufficient appropriation dollars in order that all veterans who meet eligibility requirements for health care receive it. This would include, of course, the provision of specific appropriation support for any medical program directed by the Congress.

Another problem facing VA health-care planners is the fact that not all category "A" veterans are entitled to the same care. For example, the majority of non-service-connected category "A" veterans are entitled only to in-patient care, but are not entitled to out-patient services. Not only does this present a planning problem with respect to assessing how many veterans are going to be receiving a certain form of care, it is also harmful to veterans and expensive to the VA as well.

A sound medical program emphasizes preventive care and this is achieved through out-patient services and monitoring. When a veteran has unhindered access to preventive/out-patient care, serious illnesses may be avoided altogether and when they do unavoidably occur, their effect may be ameliorated. This is not only better for the veteran patient, but it saves the VA money since the incidence of long-term, high cost serious illness is reduced.

The VFW strongly believes that the Secretary's Commission on health-care should focus on ways to provide veterans with such a full continuum of care. Total health care embraces preventive medicine, the provision of acute care services as well as long-term care, and the availability of a full array of rehabilitative and social support services.

In a related area, we will urge the Commission to support establishing the provision of nursing home care as an entitlement for all those veterans now entitled to in-patient care. This is a logical step and an essential component in fully providing veterans health care. This has the additional merit of simplifying VA planning since it would be far easier to assess how many veterans will be utilizing nursing home care.

These and other VFW concerns notwithstanding, we believe that if caution and respect for this Nation's veterans is maintained as an integral part of the process, the Secretary's Commission may well produce some beneficial results. We believe the Commission must concern itself exclusively with improving veterans health care. If, for example, ways of doing more for less are devised, then any attendant

savings should be channeled into the veterans health-care program and not incorporated into Federal budget cutting schemes.

Although we would encourage the Commission to search out ways of providing health care more efficiently and effectively, we would strongly caution against straying into the morass of achieving efficiencies for efficiency's sake and neglecting the human part of the equation. Such a course would clearly be harmful to veterans.

For our part, the VFW is, as always, prepared to play a strong and positive role in improving the VA health-care system. It is our fervent wish that the Secretary's Commission will truly attempt to strengthen veterans health care and will make no recommendations whatsoever that would be harmful to it.

In conclusion, Mr. Chairman, I would like to once again commend you and the other members of this Committee for addressing this issue here today. I would point out that germane VFW resolutions are appended to this statement and that I would be happy to respond to any questions you may have.

RESOLUTION No. 601

CATEGORY "A" VETERANS ENTITLEMENT TO OUTPATIENT CARE

WHEREAS, a sound medical program emphasizing preventive care is best accomplished by access to outpatient treatment; and

WHEREAS, certain Category "A" veterans are entitled to outpatient care under the means test; and

WHEREAS, the majority of non-service-connected veterans are entitled only to inpatient care and, therefore, can be expected to delay seeking help until a condition deteriorates to a potentially life threatening level requiring inpatient care; and

WHEREAS, those non-service-connected veterans classified as Category "A" are the most needy of the veteran population; now, therefore

BE IT RESOLVED, by the 90th National Convention of the Veterans of Foreign Wars of the United States, that all veterans classified as Category "A" be entitled to outpatient treatment by the Department of Veterans Affairs.

Adopted by the 90th National Convention of the Veterans of Foreign Wars of the United States, held in Las Vegas, Nevada, August 18–25, 1989.

RESOLUTION No. 618

ENSURING A GUARANTEED ENTITLEMENT TO MEDICAL CARE

WHEREAS, Section 310 of Title 38, United States Code, clearly delineates an entitlement to compensation for service connected wounds, disease or injury and announces an intent to pay that compensation; and

WHEREAS, Sections 610 and 612 of Title 38, United States Code, which establish eligibility for hospital, nursing home, domiciliary care, and medical treatment, respectively, imply a substantially reduced entitlement, in that, a clear statement of obligation by the Government to pay for this care is conspicuously absent; and

WHEREAS, a succession of laws enacted by the Congress have stipulated a specific entitlement to certain types and levels of medical care for certain classes of veterans; for example, those who are service connected; and

WHEREAS, there is no binding language placing the Government in the position of obliger in terms of precise levels of funding for this medical care that it directs to be provided, this entitlement is substantially diminished; and

WHEREAS, this circumstance places the Department of Veterans Affairs, as the agent for the veterans it serves, in the position of perpetual supplicant in the matter of obtaining funds to carry out the mandates of the law; and

WHEREAS, this situation impacts adversely upon veterans seeking medical care under programs clearly intended by the Congress; now, therefore

BE IT RESOLVED, by the 90th National Convention of the Veterans of Foreign Wars of the United States, that Section 651 of Title 2, United States Code, be amended to expand the meaning of the term "entitlement" to recognize an obligation and a requirement to adequately fund programs to a class of individuals, i.e., veterans, who meet eligibility requirements for a service provided by the Government and established in law as an entitlement; and

BE IT FURTHER RESOLVED, that this obligation and requirement to adequately fund programs be construed to mean that specific appropriation support must be established for any medical programs directed by the Congress to be provided to veterans, both now and in the future.

Adopted by the 90th National Convention of the Veterans of Foreign Wars of the United States, held in Las Vegas, Nevada, August 18-25, 1989.

RESOLUTION No. 691

GUARANTEED ENTITLEMENT TO NURSING HOME CARE

WHEREAS, Section 610 of Title 38, United States Code, stipulates in detail those for whom VA shall furnish hospital care, this section limits nursing home care to "may" be provided; and

WHEREAS, this is clearly discriminatory in that a veteran entitled by law to inpatient care ceases to have that protection should his service-connected condition, for example, deteriorate to a state requiring long-term nursing home care; and

WHEREAS, this discretionary loophole may serve as an underlying factor in VA's reluctance to convert beds to the long-term needs of aging veterans; and

WHEREAS, surely it cannot be the intent of the Congress to define eligibility for inpatient hospital care and exclude those eligibles who, following acute or intermediate care, now find themselves in need of nursing home care; now, therefore

BE IT RESOLVED, by the 90th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress to so amend Section 610 of Title 38, as to mandate the provision of nursing home care for those now entitled to inpatient care.

Adopted by the 90th National Convention of the Veterans of Foreign Wars of the United States, held in Las Vegas, Nevada, August 18-25, 1989.

RESOLUTION No. 751

VA COMMISSION ON REALIGNMENT AND MAJOR MISSION CHANGE

WHEREAS, the Secretary of Veterans Affairs has transmitted to the Congress proposed legislation to create a VA Commission on Realignment and Major Mission Change that would require the Secretary and the Congress to accept or reject, in its entirety, the recommendations of said Commission; and

WHEREAS, in announcing this initiative, the Secretary stressed that the Commission would not consider facility closures, but instead focus on necessary mission changes and program alignments, with attention to quality of care; and

WHEREAS, such mission changes and program alignments could preclude veterans (including some Category "A") from receiving outpatient and long-term care since eligibility for such care under current law is not mandatory; and

WHEREAS, during the past 12 years budgets for veterans health care submitted by the Executive Branch and enacted by the Congress have been inadequate, and without assurance by the President and the Congress that adequate funds will be available in future years the potential for diminished VA health-care services is assured; and

WHEREAS, Congress has the authority to establish veterans health-care policy and in exercising such authority should reserve the right to accept or modify any Administration proposal following public oversight and legislative hearings; now, therefore

BE IT RESOLVED, by the 90th National Convention of the Veterans of Foreign Wars of the United States, that the organization defers judgment at this time in supporting the role of this Commission; and

BE IT FURTHER RESOLVED, that if the Commission is established the VFW will cooperate with the Commission, provide input into its deliberations which reflect the organization's views on veterans' health-care needs, closely monitor its activities, and reserve the option of supporting or rejecting the final recommendations (or any part thereof) of the Commission.

Adopted by the 90th National Convention of the Veterans of Foreign Wars of the United States, held in Las Vegas, Nevada, August 18-25, 1989.

PREPARED STATEMENT OF R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on the proposed blue ribbon commission to review the missions of VA medical centers which would be established by the Secretary of Veterans Affairs. We will also comment on S. 1332 introduced by Senator Murkowski and S. 1398 introduced by you, Mr. Chairman, and

Senator Murkowski at the request of the Administration, which would authorize the establishment of a Congressional Commission to accomplish the same purpose.

The Secretary has decided to move forward unilaterally and create what he called "a unique commission to examine future strategies for the VA health-care system." Little is known about what underlying objectives the Secretary has set for the Commission. But, in light of the recent revelations coming out of the Central Office concerning potential benefit reforms, PVA is deeply concerned that the basic motivation behind the Commission is not just to "improve efficiency" in the VA health-care system, but serve as a vehicle completely alter how VA health care is provided and who will receive that care. In each instance, we believe the Department's goals could be fewer services and fewer veterans eligible for those services.

Even though the cost operating the Commission is to be borrowed from already severely strained medical care resources, the Secretary is fully within his mandate to proceed to appoint the 15 members of the Commission, designate an executive director, and allocate 30 career VA employees to staff Commission operations for a period of 18 months. However, PVA would caution the members of this Committee that the Department's stated goal, "to ensure eligible veterans receive the kinds of care they need (and that) care is high quality and cost-effective, and access to care is equitable," could be misleading. From our perspective the objective of the Commission is to provide the Administration with proposals that will recommend completely altering the shape, size and scope of VA health care as we know it today. If this were to happen, thousands of currently eligible veterans would have to seek alternative health care at additional cost to the Government, and the Nation will have lost a major health care asset.

Mr. Chairman, it is a sad state of affairs when our Government finally admits it can no longer afford to care for those who have served in defense of this Nation. But that is exactly the message that is being sent out of VA Central Office these days. Former OMB Director David Stockman's solution to the cost of veterans' health care in the early days of the Reagan Administration was to "shrink the system slowly over time." The Commission, we believe, is designed to provide the initial basis to help make this objective a final reality.

Ironically, the Department is already proceeding with certain forms of realignment and consolidation without even appointing a single member to the Commission. The Secretary has announced plans to eliminate the Medical Districts and consolidate the Medical Regions. Current funding shortfalls, unacknowledged by VA Central Office, are causing massive bed closures and severe restrictions and rationing of all forms of health-care services for veterans throughout the VA system. A sizable portion of the VA health-care system has already "realigned" itself out of business, not because of a lack of patient demand, but because of a lack of resources to maintain adequate service levels.

Closer to home for PVA there appear to be unexplained delays, some of them indefinite delays, in virtually all planned spinal cord injury center projects. In addition to saving construction dollars, this delay in updating needed facilities will have a direct effect on who can get care and what kind of care they will receive. In addition, the Secretary has agreed to "decentralize" the position of the Director of the Spinal Cord Injury Service out of the Central Office to the Tampa, FL VAMC—one of the busiest and most overburdened SCI centers in the Nation. This move will do very little to improve care at that facility or at any one of the 21 SCI centers under the current director's charge. We strongly believe the decision will cause irreparable harm to the proper management and provision of SCI services throughout the Nation.

The Secretary has said, "there are no sacred cows." In his urge to reform, he has said, "everything is on the table." As we have said, the role of the Commission will be to recommend sweeping changes in eligibility and the provision of services. At the same time, we caution the Committee to carefully monitor the seemingly smaller management "corrections" which can have just as much effect on the quality and quantity of care provided for our Nation's veterans.

The Commission's stated objective would be to review the mission and operation of each of the VA's 172 medical centers, nursing homes and outpatient clinics to make recommendations how best to reorganize, consolidate or streamline health-care services to meet existing and projected demand. Reorganization and improved efficiency are fine goals. In fact, PVA on its own, and through the Independent Budget, has endorsed the concept of a VA health-care commission that could, under certain circumstances, make recommendations that could properly match a realistic estimate of veteran health-care demand with the most efficient means of providing those services. PVA has no objection to efficiencies in management and services that can be developed to care for our Nation's veterans in the most cost-effective

way. If the Commission's charge stopped at that point we would have no concerns. However, we believe the purpose and design of the Commission go far beyond that point.

Apart from flaws with the conceptual framework of the Commission, we believe the Commission can't realistically accomplish what it is going to set out to do. It is virtually impossible for the Commission members to recommend changes in the delivery of services when they cannot define exactly who is entitled to receive those services now and is the future. There is currently no clear entitlement for the full range of VA health care for any veteran. Certain veterans are entitled to some things, inpatient care for instance, but not outpatient services or nursing home care. Some veterans can receive outpatient services, but only on the recommendation of a physician to obviate the need for inpatient care; (and in most cases now) only if resources are available. This is not only inefficient, but bad medicine.

If the Commission were successful in having its recommendations adopted to alter the missions of certain VA medical facilities without first defining entitlement, then the availability of services would be manipulated by another artificial factor—first by available resources; and then by the availability of facilities themselves and the type of services they were physically able to provide. PVA finds this the most serious and dangerous underlying flaw in any "mission commission" proposal. Without first defining entitlement, it becomes very easy, but very dangerous, to shape the system to control who gets in and who stays out. The end result has no relationship whatsoever to the actual demand for care from potentially eligible veterans in any given catchment area.

When questioned on this point, the Department responded to PVA that, indeed, one of the first charges of the Commission would be to look at, and then make proposals that would define entitlement and access to care. We cannot object more strongly to this premise. Definition of entitlement, while needed, is the responsibility of the Congress of the United States. It is not the role of an advisory committee appointed by the Department of Veterans Affairs. The House has already passed legislation that would provide clear entitlement for outpatient services for category A eligible veterans. We urge the Senate Veterans' Affairs Committee to agree to this provision. We also call on both the House and Senate Committees on Veterans' Affairs to expand entitlement to cover nursing home care as well. Only then can anyone make any reasonable assessment of what VA health care must do to meet its true obligations now and what those obligations should be in the future. The idea that appointed commission members would sit down and decide who, in their opinion, should be eligible for services, and then use that determination as the basis for making proposals which could very well recommend sweeping changes in how VA health care is provided, would seriously compromise the credulity of any recommendation the Commission might make.

Mr. Chairman, both you and Senator Murkowski have introduced legislation, S. 1332 and S. 1398, which would establish a Commission similar to that already being appointed by the Secretary. The only conceptual difference between the two being, your Commission would have a congressional mandate and reporting authority. The Secretary is already proceeding with the establishment of his Commission, whose mission, as we have just stated, is already clearly compromised by the question of uncertain entitlement definition. Under these circumstances, we believe that any Commission, no matter what its appointed authority, either from the Congress or the Administration, would be serving under the same flawed assumptions until a clear definition of entitlement for health-care services can be established by law. On that basis, we believe that the establishment of a second Congressional Commission, or even a legislative Commission that would usurp the function of the Secretary's Commission, to be unwise at this time.

In the end, Mr. Chairman, it will be up to you, your Committee and the Congress to review, accept or reject any recommendation brought forward from the Secretary's Commission. We urge you, at that time, to judge the worth of these recommendations with a careful eye to maintain the commitment between the United States Government and the men and women who have served, and will serve, in defense of this Nation.

Thank you for the opportunity to present the views of Paralyzed Veterans of America. I will be happy to respond to any questions you might have.

PREPARED STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. Chairman and members of the Committee, the Vietnam Veterans of American, Inc. (VVA) appreciates the opportunity to present its views regarding provision for realignment and major mission changes of medical facilities of the Department of Veterans Affairs.

Opportunities Offered by the Commission

VVA supports the proposed initiatives to provide realignment and major mission changes, as necessary, of medical facilities in the Department of Veterans Affairs. The Commission offers all concerned an opportunity to know what is truly required to care for veterans in medical facilities in terms of required commitments, resources, programs, and most of all, costs.

Leadership in certain veteran services organizations, and Congress, and the Veterans' Administration, in their sincere attempt to protect what resources were available to the VA health-care system, may have over the years inadvertently shielded the public from coming to grips with the true expense of veterans health-care delivery. In turn, the veteran may have been "short changed" by the process, and the public denied the opportunity to either take responsibility for the American commitment to its veterans or to reassess that commitment.

The Commission offers all concerned an opportunity to understand and envision the mission of medical facilities of the Department of Veterans Affairs (DVA) in the context of the national health-care system which includes not only the health-care system of the Department of Defense (DOD) and the affiliating medical teaching colleges, but the larger system of community, municipal, and State health systems—both private and public, proprietary and nonprofit.

We all know that as health-care costs continue to raise at a faster rate than inflation, and the Government finding it more and more difficult to fund health care, the VA health-care system will continue to be a target for limited funding. Therefore, it is imperative that the missions of each medical facility is defined in terms program precision, effectiveness, efficiency, and realistic economies relative to delivery of health care to veterans in a constantly changing environment.

The Commission offers the Veterans Health Care System an opportunity at the medical facilities level to organize itself as a more efficient organization in the communities it serves in addition to achieving appropriate recognition relative to the overall system, especially regarding decision-making and veteran input at the service level.

Tom Peters in his series "Thriving On Chaos," notes, "if it is not broken, fix it!" He attests to the need to not only flatten organization hierarchical structures to include both the provider and the recipient of services in all critical decisions relative to an organization's existence, survival, and productivity, but to recognize that it is the quality of the product that is the ultimate determinant of success. He notes that the best way to produce, indeed, the only way to produce, is to surrender power to the team of providers and recipients of services in equal partnerships as a driving force in thriving on the chaos of the marketplace. Clearly, in our new environments, the aphorism "if it ain't broke, don't fix it" is rapidly loosing its relevance.

Concerns and the Commission

Both S. 1332 (the "Department of Veterans Affairs Medical Facilities Realignment Act of 1989") and S. 1398 (the "Department of Veterans Affairs Health Care Quality Assistance and Cost Effectiveness Act of 1989") address membership requirements for the Commission. Neither of these bills appear to be sensitive to the need to have direct input from either the veterans that used the VA health-care system at the functional level nor to the providers at the same patient care level. We strongly recommend that as missions are defined and redefined at the medical center level, the Commission takes into consideration the views of both staff and veteran patients.

We strongly support the requirement that a separate budget be established for the Commission and its operations. The Department of Veterans Affairs has, over the years, had to absorb costs for salaries, new programs and new initiatives, cost of living increases, inflationary cost, etc. The approximately $1 billion the Department has requested for fiscal year 1991 for VHS&RA could be used totally to simply fill in the budgetary "holes" caused by having had to absorb those additional costs. This means there will be almost no new money for fiscal year 1991 if the Secretary's request is granted. Even for fiscal year 1990 (current), it has become abundantly clear that at least $350 million will be needed in spite of the Secretary's statements that

he will not come in for supplemental dollars. Therefore, the DVA should not be expected to absorb the cost for the Commission.

We strongly request that the Commission not be used as a device to either justify savings, or as a rationale to facilitate the Department contributing toward Budget Deficit Reduction. We believe veterans want to do their share in contributing to the economic strength of this country while at the same time the country wants to remember the contributions veterans have made to its well-being.

We strongly request that the Commission not be used as a device to either continue a process of centralizing operational control of the Agency to DVA Central Office at the expense of the "Field" nor as a device to indirectly cope with issues of potential micromanagement by or within either congressional, Federal, or advocacy institutions.

We are hopeful that the Commission will be seen and used as an opportunity to improve the DVA Health Care System which by the accounts of many, is in serious trouble. Once again, thank you for this opportunity to present our views.

PREPARED STATEMENT OF JOHN F. SOMMER, JR., DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the Committee, The American Legion appreciates the opportunity to briefly comment on the two proposals relating to the future structure of veterans health-care services scheduled for consideration at today's hearing and to set forth its views on the Secretary's proposed Commission on the Future Structure of Veterans' Health Care.

With respect to S. 1332 this measure would require the Secretary of Veterans Affairs to establish a Commission to review VA medical facilities to determine if realignments or mission changes, to include possible closure, are needed. It requires the Commission to be established within 45 days following the date of enactment of this bill; and that a charter be issued setting forth the terms, conditions, and mandates for the Commission's operation to achieve its objectives, including provision for the appointment of staff and any other support and expenses the Commission considers necessary.

This bill would require that the Secretary approve or disapprove, without change, all recommendations contained in the final report which is required to be submitted to the Secretary. There would be no provision to approve a partial list or modify any recommendations. Unless a joint resolution disapproving the recommendations is enacted by Congress within 45 working days after receiving the Secretary's report, the Secretary is required to begin implementation efforts within 1 year after receipt of the report and complete those actions within 3 years.

S. 1398 shares similar objectives as S. 1332, with some variations. Essentially, this measure would also establish an independent, broadbased Commission, to review, evaluate, and develop recommendations for needed changes in the Veterans Health Services and Research Administration. The proposed Commission would review and evaluate all VA health-care facilities, to include consideration of realignments or facility mission changes to assure that VHS&RA can provide quality medical care effectively and efficiently while meeting its goal of affording eligible veterans equitable access to such care.

Under this proposal, the Secretary would transmit to the Congressional Committees on Veterans Affairs a copy of the Commission's report and a report containing a statement setting forth those medical facility realignments and major mission changes recommended by the Commission. This bill would require the Secretary to carry out and complete all recommendations within 6 years.

The Secretary would not carry out realignments or major mission changes if, within 4 months of the transmittal of the report by the Secretary to the Congressional Committees on Veterans Affairs, a joint resolution was enacted by Congress disapproving all of the recommendations of the Commission. Under this measure, the joint resolution would only provide for disapproval of all recommendations and would not delete or amend any recommendations for realigning or changing the major mission of any medical facility. According to definitions contained in this proposal, the term "major mission change" means any substantive change in clinical programs or patterns of medical care delivery at a medical facility, and "realignment" means any merging of the functions, activities, staff, or property of two or more medical facilities, or any relocation of functions at or from any medical facility. By definition, no provision is included that would permit the outright closure of any VA medical facility.

Mr. Chairman, The American Legion has long been an advocate of providing necessary medical care services to our veteran population in an economically sound manner. Recently, we have witnessed the VA medical care system facing unprecedented funding shortages on many fronts. These shortages have occurred due to a myriad of factors. During the past two decades inflation in the delivery of medical care and related services has risen faster than other goods and services as a whole. New technology creates a demand for increased funding and usage of modern medical equipment. The average age of the veteran population continues to increase, with the average age of WWII veterans now 68 years. With advancing age, veterans require more expensive health-care services, both acute and long-term.

We believe, Mr. Chairman, that VA needs to properly assess the medical needs of veterans over the next several decades and be prepared to provide the appropriate mix of services to accommodate those needs. We believe the objectives of such a Commission can be appropriately met through the administrative creation of such an advisory panel, and that a statutorily empowered Commission is not necessary.

Mr. Chairman, The American Legion is supportive of the need to plan for and provide the best mix of available health care services in an equitable manner to all deserving veterans. In our view, the work of the proposed commission whether administratively or legislatively established should not be kept secret from those whom the Commission is intended to serve, and that is the veteran community. In this regard, we would recommend that a summary of all Commission proceedings, as well as all records, documents, and other materials developed by the Commission be made available to veteran service organizations. This would include the records of field hearings and all medical facility visitations. Additionally, we believe the Veterans' Affairs Committees should be kept apprised of the Commission's activities.

With respect to the legislative proposals, we do not believe the provision contained in both bills to grant the Secretary of Veterans Affairs waiver authority to carry out any reorganizations is appropriate without congressional oversight.

Both S. 1332 and S.funding to support the Commission from VA medical care accounts. Mr. Chairman, we are concerned about a reduction of direct patient care funds when the VA medical system already cannot support all needy veterans who apply for care. We suggest a special fund be established within VA so as to provide for the costs associated with the Advisory Commission. Additionally, we trust that as has been proposed, adequate provisions will be made to return any cost savings associated with Commission recommendations to the VA medical care account.

With respect to Secretary Derwinski's proposal, we understand the Advisory Commission would be comprised of approximately 15 members to include a cross-section of health planning and policy experts. We trust that the final composition will represent a balanced Commission. We are extremely pleased that all Commission meetings and hearings are to be announced in advance and open to the public.

Mr. Chairman, it is our belief that the Commission must examine the future of the VA health-care system using the broadest inclusion of veteran eligibility guidelines. Anything less, in our opinion, will be short-sighted. Current entitlement to VA health care cannot be presumed to be absolute. Further, if the work of the Commission will be undertaken with the assumption there will not be a new generation of wartime veterans by the year 2000, then the final report of the Commission may not be totally germane by the beginning of the next century.

We do believe there are several conditional issues upon which the successful undertaking of the Commission's work depends. These include sufficient independence for the Commission Chairman and Vice Chairman to permit them to present the Commission's report and findings to Congress. There should be no obstructions or restrictions placed upon the Commission from any governmental department or agency which in any way would constrain the Commission from carrying out its prescribed mission.

Mr. Chairman, we have stated that VA has lacked a cohesive strategic plan by which to identify and address the medical needs of our veteran population, particularly the aging veteran, for a number of years. VA has made commendable progress in developing an integrated network of health-care services within certain geographic areas. However, other areas are underserved by VA, both in terms of the number of medical facilities and the diversity of services available. We firmly believe the Secretary's philosophy of "equally good access to equally good care" applies to all eligible veterans. We have found that some veterans determined by means test criteria to not be among the most needy of the veteran population still cannot obtain alternative health-care services once they are refused care by VA. Many veterans today live on the edge of what are considered as category B and category C income thresholds. Additionally, many deserving veterans cannot obtain private health-care

insurance coverage even though VA guidelines say they can afford private health care.

Mr. Chairman, we would like to see the Advisory Commission examine not only the array of services VA must be prepared to provide in the years 2000 to 2010, but also to focus on what conditional factors represent additional risk to veterans unable to obtain VA health care. In fact, this is something that should be done immediately.

In addition to looking at the future needs of the aging veteran population there are some immediate problems that need to be reviewed and remedied—to include the need for additional inpatient post-traumatic stress disorder treatment units.

Finally, Mr. Chairman, we support the Secretary's position of not accepting any facility closure recommendations. The stated objective of the Commission is not to reduce—but to improve—the delivery of health care to the Nation's veterans.

The American Legion will closely monitor the work of the Commission and exercise our prerogative to comment on any aspect of the Commissions interim or final reports as we deem appropriate.

Mr. Chairman, that concludes our statement.

PREPARED STATEMENT OF THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

Mr. Chairman and Committee members, on behalf of the National Federation of Federal Employees, which represents 14,000 employees of the Department of Veterans Affairs, most of whom work at VA hospitals and outpatient clinics, I appreciate the opportunity to submit our views on S. 1398, S. 1332, and on the proposed VA Commission on the Future Structure of Veterans Health Care.

I wish to commend the Committee members for their recognition of the problems facing the Department. I also commend the Committee for its hard work in eradicating these problems.

The National Federation of Federal Employees believes that it is appropriate and necessary for the Department of Veterans Affairs to undergo a complete review of the veterans health care system and for adjustments to be made to assure high quality care for veterans during the coming years. NFFE, however, is concerned that the manner in which this review will take place could result in the best intentions going awry. Even with the best intentions, a flawed review procedure will inevitably produce a flawed result.

For example NFFE had serious concerns and objections to the procedures utilized by another recent commission established to effect the recent military base closures and realignments. In fact, NFFE filed suit in Federal court to prevent that commission's recommendation regarding military base closures. We urged the court to find that the process by which the recommendations were reached was unconstitutional and a violation of the Administrative Procedure Act.

Specifically, the Base Closure Commission's report was replete with erroneous and out-of-date information. We felt that the Commission failed to fulfill its obligations to Congress and the Nation. That Commission was set up originally by the Secretary of Defense as an advisory panel, much like the proposed VA Commission. By passing the Base Closure Act in October of 1988, however, Congress gave that Commission almost unfettered discretion regarding which U.S. military facilities to close or realign. When Congress failed to override the "all or nothing" recommendations of the Commission, its recommendations became law. The result is flawed public policy. We cannot let this happen again.

In light of NFFE's dissatisfaction over the process utilized by the legislatively-mandated Base Closure Commission, the establishment of yet another commission, this time for the VA, gave us great cause for concern. It appears, however, that notwithstanding the consideration of S. 1332 and S. 1398, Mr. Derwinski, Secretary of Veterans Affairs, is establishing a 15-member administrative commission to study the future needs of the VA. We expect that the VA Commission's recommendations will be purely advisory in nature as opposed to the "all or nothing" choice that was offered by the Base Closure Commission and that has been proposed in both S. 1332 and S. 1398. We urge that the VA Commission remain purely advisory, leaving to Congress the flexibility to establish a coherent public policy.

There are other important lessons that can be gleaned from the Base Closure Commission's experiences as well. For example, we strongly urge that the Commission conduct all of its hearings and meetings publicly and that the Commission make all of its determinations in public, rather than in private executive sessions, in accordance with section 10 of the Federal Advisory Committee Act. We recom-

mend further that the Commission's studies and recommendations be subject to the Freedom of Information Act.

It is, also imperative that the VA Commission be given ample time to reach its conclusions so as not to rush to judgment. Any conclusions reached should also be subject to public comment so as to air any overlooked information or dissenting views. It is our belief that the only way to gather accurate information will be for the Commission to be inclusive, rather than exclusive, in nature. For these reasons, we object to the provisions of S. 1332 and S. 1398 which exempt the Commission from public disclosure requirements.

Along these lines, we believe that input from NFFE and other organizations representing VA employees regarding what is needed and most efficient is essential. Employee representatives, such as NFFE, already have national consultation rights on major personnel matters at the VA in accordance with Federal labor law. At this juncture, we believe that employee input on the Commission is appropriate as well. While the Commission's mission remains vague and focused primarily on future service delivery to veterans, any realignment or mission change will have a major impact on the staff of the VA.

The paramount issue facing the Commission is how to organize the VA system to serve veterans in the most effective and efficient manner. Any conclusions to this query that are made without input from the employees who deliver the services—workers in the 172 VA hospitals—would be incomplete at best.

Past experiences have shown us that politics or policymaking by exclusion is a fatally-flawed method of operation. The employees in VA hospitals are a uniquely dedicated group who are fundamentally more concerned with proper care for their patients than they have been for their own financial well-being and welfare. The day-to-day experiences and opinions formed by the nurses, pharmacists, social workers, nurse practitioners, LPNs and other employees would be an invaluable component of any decisions regarding the future missions of the VA. To put it bluntly, you've got to ask the people who work there.

NFFE strongly urges that the 15-member Commission have representation from employee groups. For this reason, we cannot support S. 1332, which, for reasons unknown, explicitly prohibits employees of the Department of Veterans Affairs from serving on the Commission.

NFFE would be pleased to submit the name or names of VA employees who would be an asset to the Commission and who would be honored to work with the Commission. At a minimum, we feel that there must be some formal mechanism whereby unions representing VA employees will have input into the Commission's decision process.

There has not been a wealth of information given thus far regarding the specific goals that Secretary N has set for his Commission. The two bills before us today differ on key definitions, which would dictate the scope of the Commission's mission. We urge that the Commission and this oversight Committee adopt the view that the term realignment does not mean closures, as defined in S. 1332.

As care-providers, NFFE is concerned that any "mission change" might adversely affect thousands of currently eligible veterans for whom this Nation has already extended a commitment of care. For instance, in the New York City area, it is estimated that as many as 100,000 veterans suffer from what is termed "non-service-connected" medical problems, such as mental illness. And in most instances there are no reasonable alternatives for health care. What will happen to these veterans if the Commission decides that the mission of the VA should no longer encompass a commitment to these persons?

In appointing the Commission members, it is also important to recognize that the needs of veterans in one locale may differ from the needs of veterans in another area clear across the country. We are hopeful, therefore, that the Commission will include a cross-section of persons from different geographical localities, as opposed to a Commission with a decidedly "Beltway mentality."

We look forward to working with this Committee, the Department of Veterans Affairs and with the Commission to improve patient care and the delivery of services. This concludes my statement and I would be happy to answer any questions that you may have at this time.

PREPARED STATEMENT OF CLAUDETTE MORRISSEY, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

Mr. Chairman and members of the Committee, on behalf of the Nurses Organization of Veterans Affairs (NOVA), I thank you for the opportunity to present our

comments and recommendations on the appointment of an independent commission to examine and report on the future structure of the entire VA Health-Care System as well as on S. 1332 and S. 1398.

It has always been NOVA's goal to help assure that veterans needing health care, promptly receive quality care. It is with this goal in mind that NOVA commends Secretary Derwinski for his philosophy of "equally good access to equally good care" and share his belief that "it is imperative that the Department improve the structure, organization, and delivery of VA health-care services." VA nurses are is the forefront in programs providing care for veterans in the full continuum of acute and long-term hospital care, as well as nursing home care, ambulatory care and home care, and it is our goal for the care we give to be "good care."

NOVA certainly agrees with the premises outlined in Section 2 of S. 1398 describing shifts in veteran population and the reality of modern medical and health care as well as community care. We agree the time has come to review the VA health system to assure that it is able to meet the obligation this Nation has to care for the men and women who have served in the defense of our country.

Years of continual inadequate funding with alterations in eligibility and access to veteran health care trigger concern for the system's continued viability. There is a need for VA to define its present, as well as future, objectives and to develop a strategic plan to meet those objectives with sufficient resources for personnel, physical plants, equipment and technology, innovative health-care delivery processes and programs. Veteran eligibility guidelines need to take into consideration the modern medical reality that many services are best provided on an outpatient basis. The VA health-care system experiences a situation similar to that of the American health-care system as it faces increased health-care expenditures, more modern technology and increased longevity of the population served. In the midst of a health-care crisis in our country, the results of the Commission study may provide the opportunity to improve a system that could be a model for the provision of care in the future.

The VA Health-Care System offers much to the Nation and has served and continues to serve as a model in many areas. In addition to providing a continuum of comprehensive services to veterans, VA medical centers are a major source of education for nurses, physicians, and other health practitioners. VA also serves a role in research, and as a national emergency contingency backup system as well as a sharing resource for the DOD. At a time when health-care leadership is needed for the Nation, it is indeed fortunate that such a large health-care system can be evaluated, and that the evaluation, if done well, may point the way for our Nation. Whatever the delivery system, supply, or mix of personnel and facilities for populations in underserved areas may need in the future, VA is presently the Vanguard in health-care programs for gerontology, long-term care, AIDS, PTSD, spinal cord injury, severe and chronic psychiatric problems, alcohol and substance abuse, and the homeless.

A review of the mission and reorganization for improved efficiency are noble goals. NOVA has no objection to the Commission being charged with the goals. We do, however, prefer the definition of realignment as stated in S. 1398, and object to the definition of realignment as stated in S. 1332, because it appears to indicate a primary goal of reductions and relocations of functions and staff, and fear that this will serve the agenda of some who wish to see only VA consolidations and closures and not improvements. NOVA strongly supports the belief that the Congress and the Veterans Service Organizations have a role to play in the Commission's review and recommendations for the future of the Veterans Health-Care System.

It is NOVA's hope that the proposed Commission will fulfill the promise of preparing VA to develop and provide the necessary services to treat a population of aging veterans who need and deserve care and treatment. NOVA supports a VA mission of primary acute care, long-term care, ambulatory care, and home care. It is evident to nurses at the bedside that veterans who require hospitalization need to be able to receive outpatient services in many forms: outpatient clinic treatment, increased direct patient services by HBHC, and expanded Adult Day Health Care, to name a few.

Nurses are the largest number of direct care providers in the VA system, and are crucial to the continuum of care. It is NOVA's expectation that at whatever level decisions are made about VA health care and for the development of strategic plans, at all stages and levels, the voice of nurses must be present. NOVA urges the appointment of at least two nurses to the Commission. Distinguished nurses with experience in academia, public policy, health policy, hospital administration, clinical practice, and research would greatly enhance the ability of the Commission to meet its goals. The expertise of nurses on the Commission will help assure that the deci-

sions being made will be evaluated for the impact on veteran patients as well as the VA health-care system.

It is NOVA's hope that when the time comes for this Committee to review the recommendations of the Commission, you will evaluate and support the recommendations that will improve the ability of VA health-care professionals to provide the quality health care that is a promise and a commitment made to the men and women who have served in defense of this Nation.

Thank you for the opportunity to present this statement.

PREPARED STATEMENT OF DR. PAUL W. SCHAFER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS

Mr. Chairman, members of the Committee, my name is Paul W. Schafer, M.D. Though I am the full-time Chief of Thoracic Surgery at the Washington, DC Veterans Medical Center, I appear here today as the Executive Director of the National Association of VA Physicians and Dentists. We appreciate this opportunity to express our views concerning the VA Commission on the Future Structure of Veterans Health Care, which the Secretary of Veterans Affairs has established administratively.

After review of published materials, congressional testimony, and interviews, the conclusion can not be escaped that a major undertaking is being proposed. Though many of its announced features are meritorious, the question arises: if perchance, too much is not being asked of too few, in too short a period of time, and perhaps, even at the wrong time.

We are, after all, considering how our Nation will honor its contract to provide first-class health care to those who have served. The instrument which honors this contract is our country's largest health-care delivery system, a most complex system of people and parts, a system which almost miraculously still manages to function in spite of chronic underfunding and ever-increasing responsibilities. It is by far the best health-care bargain to be found anywhere in our society. Bargain in the sense of its health-care product; not in the bottom-line shareholder profits being earned by the corporate health-care giants that are taking over the delivery of a questionable health-care product in much of the private sector. Never must we lose sight of the fact that the veterans health-care delivery system, though it has many other functions, has as the principle reason for its existence, the delivery of quality health care to those it serves.

This brings us to our first area of concern. The past year's planning for this Commission, which will address the future structure of veterans' health care, has gone on at a time when morale among the health-care professionals in the Central Office of the Department is at an understandable, all-time, rock-bottom low. It is now approaching a year since the Chief Medical Director of the Veterans Health Services and Research Administration (VHS&RA), formerly the Department of Medicine and Surgery (DM&S), was turned into a lame-duck, nonleader. Much evidence suggests that the DVA Secretary and his Deputy would not be uncomfortable managing the Department with less, rather than more, input from VHS&RA health-care professionals, who still remain in titular leadership positions. NAVAPD questions how much health-care expertise one could find on the 10th floor of Departmental Headquarters. And we are talking about a health-care delivery system, not a chain of Howard Johnson motels.

Absent a meaningful supplemental appropriation for the current fiscal year, the Commission will begin its work just as the system enters its last FY 1990 quarter of agonal fiscal distress. Commission members will see clear evidence that denial care has become a tool lay managers have used for resource conservation.

Many forces are at work to put more and more management authority into the hands of local Facility Directors. As this course is questioned, the assurance is given that most managers will do a good job and that those who fail to perform in a satisfactory fashion will be removed from their responsibilities. One obvious concern is that lay managers will short change health-care functions and those who provide them, favoring instead their own administrative fiefdoms.

You judge for yourself how you would characterize the January 1990 Cincinnati VAMC plan which follows:

PROPOSED OR PLANNED MANAGEMENT ACTIONS TO REDUCE/ELIMINATE DEFICIT

—Reduce Physician Salaries: $750,000–800,000
—Close Orthopedics
—Close a 36-Bed Surgical Unit (5 North)

—Close 3 of 6 OR's (Cost Avoidance)
—Reduce Workload
Inpatients Treated—500 less than FY 1989
Outpatients Visits—15,000 less visits than FY 1989
—Downsize or Close Hemodialysis and Home Dialysis
—Continue Tight Controls on MRI's, Angioplasties, Cardiac Surgery, and other tests and procedures
—Continue Employment Freeze
—Change ER to Triage/Admissions Unit
—No Funds for Performance Awards (Includes PMRS & SES)
—FURLOUGH ALL Employees during this Fiscal Year
Salary equivalent to GS–6 and below—20 hours
Salary equivalent to GS–7 and above—50 hours.

This can't be called management, it is nothing short of administratively sanctioned malpractice. It stinks to high heaven.

The bulk of the Commission's work will occur during FY 1991, VA Medical Program funding for which the Administration has been much praised, since it represents a $1 billion increase over the admittedly inadequate FY 1990 level. However, on careful analysis this increase almost completely fails to focus on the vital and serious problems which have been voluminously documented.

Ninety-one and four-tenths percent of the increase goes for inflation and rate changes, facility activation, 1990 and 1991 pay raises, FERS, special salary rates, and an additional work day. Not a penny of this will go for desperately needed maintenance, modernization, and procurement of health-care equipment.

No constructive rational thought processes could possibly have been involved in the Administration's proposed solution for the impending catastrophe represented by the program's inability to compete in the marketplace for first-class health-care providers. The proposal to offer only a $31.4 million pay raise for nurses (that's less than a $1,000 increase per nurse per year), only a $38.6 million pay raise for physicians and dentists (that's less than $3,000 per person per year), and nothing for other critical health-care providers is nothing less than adding insult to injury, to which was than added a reduction in funding for research.

In the case of physicians and dentists, not less than an increase of $175 million is required just to bring the purchasing power of their take-home pay to the level provided by Public Law 96–330 10 years ago, after which one needs to assess how much of an actual pay increase will be needed for the Department to recruit and to retain a first-class staff of physicians and dentists.

It is surely obvious to any knowledgeable person that the Administration's proposal concerning this matter is nothing less than a miserable failure.

Absent a substantial congressional action to increase the pay of VA health-care professionals, the Commission will come face-to-face with an almost gutted professional staff serving in our health-care delivery facilities. And the Department itself must bear a large measure of responsibility for this circumstance. Under duress, last fall, its leadership team sent to the congressional committees a so-called Quadrennial Report concerning the recruitment and retention of VA physicians and dentists. It is our understanding that an even less generous recommendation was sent to the Office of Management and Budget, which has yet to approve or to reveal any details of its intention other than the $38.6 million identified in the President's budget message. There has been much obfuscation and double talk about this Quad Report, which is for all practical purposes the DVA's contracted Klemm Report. It contains two very serious flaws:

1. Data from the Association of American Medical Colleges (AAMC) are used as the primary basis for the report's recommendations, since this data source was considered to be most relevant for comparison purposes with the VA. Not mentioned was the fact that the 1988–89 AAMC income of 40,327 full-time faculty excluded 5,778 individuals who are most likely to be the highest academic earners. The AAMC report identifies that the reporting institutions did not know the income of these individuals from one or more of the following sources: Practice earnings; bonus/incentive earnings from faculty practice plan year-end bonuses or incentives; and unregulated, uncontrolled, outside professional income derived from patient services.

2. Even more important is its misleading bottom line cost of $76 million. It funds $56 million of its pay improvements by reducing our existing Primary Special Pay by $5,000 per person. Absent this retrogressive factor the bottom line cost would be $132 million, this more nearly approximating the amount needed to fund an adequate pay increase.

Primary Special Pay is the only part of our Special Pay which the law (Public Law 96-330) states, "must be paid." This is no sign-up bonus; it is, in effect, an addition to our guaranteed salary, a benefit we fought for and won by override of a Presidential veto nearly 10 years ago. For it to be treated in such an insensitive and cavalier manner at this time represents a devastating blow to the morale of DVA's most important health-care providers, with disastrous results for the veterans medical program.

And now we come to our bottom line concern about this Commission. By now few informed persons doubt that successive administrations and their conservative advisers intend to do away with Veterans Medical Program as we now know it.

A former Chief Medical Director put it this way, "the President's and OMB Director David Stockman's real aim is to kill off the VA Medical System. I think that is their philosophy. If only they were honest and had the courage to state their philosophy, they would have a tremendous backlash."

In "The Triumph of Politics—Why the Reagan Revolution Failed," David A. Stockman repeatedly wrote of the intention to "shrink the system over time."

The Heritage Foundation's "Mandates for Leadership I, II, III," addressed to the first two Reagan terms and the Bush current term, put it very clearly, "The whole structure of VA health benefits has become increasingly outdated, redundant, and inefficient. Maintaining a separate federally owned and operated health-care system for veterans along with Medicaid and Medicare and private programs leads to wasteful duplication. The new President should propose a plan to convert veterans health benefits from a system of Government hospitals, doctors, and nurses to a reimbursement system like Medicare. The plan should propose privatizing the vast majority of existing VA health-care facilities by selling them to private health companies or nonprofit organizations. The plan also should include provisions to provide veterans health benefits in the form of vouchers so they can purchase insurance or health benefits in the private sector. That would satisfy the Federal Government's obligation to veterans without the wasteful cost of maintaining a separate health-care system for these Americans. In designing this voucher system, the focus should be on encouraging veterans to purchase catastrophic acute and long-term care insurance."

We suggest that all interested parties should be on notice that this Commission could become the ultimate instrument to prepare for such a recommendation. First insight into this prospect will come with the identification of those selected to serve as Commission members. We suggest that we look them over carefully, and watch their actions like a hawk.

It would surely be ironic if veterans were to be robbed of their health care at a time when, with peace breaking out all over, there will actually be a peace dividend. Giving veterans a deserved share of this dividend would be poetic justice.

STATEMENT OF DR. DONALD L. CUSTIS, FORMER CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

I appreciate the invitation to provide this statement for the Committee's record.

I concur in the opinion that an independent study of the VA health-care system is indicated for the purpose of facility and program realignment to best serve the current and future needs of veteran beneficiaries. Profound changes are occurring in the technical nature and the modalities of health-care delivery, concurrent with a geographic shift and other demographic changes in an aging veteran population. VA resources should be located to serve veterans in areas of the country having the greatest demographic need for health care. Realignment may require new facilities in some areas as well as mission change for some hospitals already existing. Furthermore, in the current environment, the outbreak of peace in Europe could result in a significant increase in military discharges with short range impact on the Department of Veterans Affairs, and yet lower out year demand than previously predicted for veterans' health care.

An objective evaluation of the VA health-care system presents an opportunity to correct its inefficiencies as well as to reaffirm its accomplishments. There is waste across the Nation's pluralistic health-care systems and no less so in that of the VA. Known duplication of programs and services by VA facilities in proximity to each other and the widespread local perception that every medical center in the system should have a tertiary care mission contribute to inefficient resource management. It is not possible to manage the system's resources effectively without an operational direction that is determined by medical center missions which, considered in their totality, will meet the Nation's health-care commitment to its veterans.

Once facility missions are reassigned, conformity should be closely monitored. The apparent lack of discipline within the health-care system dictates stronger central control. No program nor activity expansion should be allowed without central approval according to a system-wide plan.

Related to the mission imperative is the need to overcome the apparently prevalent local resistance to the conversion of excess hospital beds to nursing home care. The Commission can be of positive influence in this regard along with recommendations for specified expansion of such noninstitutional long-term care programs as geriatric day care centers and itinerant home care.

I would like to make brief reference, however, to some reservation and concerns. Appointment at this time of a study commission for realignment and major mission change of VA medical facilities may be critically premature. My reservation has to do with two missing ingredients for valid outcome of a study upon which to redesign the VA health-care system. One is the need for a more discrete and definitive set of criteria for health-care entitlement. The other is the absence of an accurate analysis of the current unmet health-care need of entitled veterans.

These two projects have been addressed for several years in the Veterans Service Organizations' Independent Budgets. We have urged that all category A veterans be granted, in addition to the already mandated inpatient treatment, clear entitlement to outpatient and nursing home care on the premise that professional ethics and a commitment to delivering quality medical care dictates that any health-care provider is responsible for the complete care of a patient or should be relieved of that responsibility altogether. Our cost analysis indicates that these additional entitlements, if properly managed, would be budget neutral.

The authors appreciate Congress' ongoing effort to accomplish this. Such legislation would eliminate current obfuscation regarding entitlement and make possible an accurate analysis of total veteran health-care need.

For the past 2 years we have, through the Independent Budget, advocated a comprehensive survey to identify the true numbers of category A veterans whose health-care needs, for one reason or another, are not being met. The recently published Government Accounting Office (GAO) survey reports unfortunately fell short of answering that question. Only when dependable data on this subject are made available can one accurately realign a health-care system to parallel a needs demography.

With the clarification of absolute entitlement for a known beneficiary population, an enrollment system could be instituted and capitation budgeting introduced. Such innovation could serve to obviate the arbitrary estimates which now invite such budget shortfalls.

Finally, there are some concerns. The very announcement of such a major reappraisal effort invites, in many quarters, fear of a possible hidden agenda. In order to allay anxieties the composite makeup of the proposed Commission should be clearly reflective of veterans interests and the membership inclusive of not only expertise in health-care planning and delivery, but also medical education and research. Academic affiliations and the VA's commitment to biomedical, rehabilitative and health services research must not be compromised. The full potential should be explored for appropriate, and only appropriate, sharing of resources with military medical services as well as with other governmental and private sector systems.

STATEMENT OF DR. A. WENDELL MUSSER, PAST PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF STAFF

Again, it is with great pleasure that I appear before the U.S. Senate's Committee on Veterans' Affairs. Thank you for allowing me to make my comments.

In 1982, the American Medical Association organized a project to provide a broad-based forum for deriving consensus on health policy for the American people. The report of that forum was entitled "Health Policy Agenda for the American People." Seven policy issues were addressed and each one of those issues makes a component part of the overall agenda necessary to address the health-care needs of the totality of American society. Those issues were: (1) Supplying Professionals; (2) Providing Technology and Facilities; (3) Organizing the Resources; (4) Communicating Health Information; (5) Insuring Quality; (6) Pay the Bill; and (7) Preparing for the Future Through Research. It would seem readily apparent that each of these major issues make up the component parts for addressing the organization alignment and mission of any health-care delivery system including the Department of Veterans Affairs.

As we all are acutely aware, the health-care system in this country is in a bit of chaos at this point in time as it attempts to address the incredible needs placed against it under the constraints of very limited resources. There are a series of key driving forces, structural changes and issues that must be addressed as we attempt to deal with the uncertainties of the future. It has been stated that no matter what the characteristic of an individual health-care system, each of these forces are worthy of special attention. A sentence or two at this point in time might be appropriate. One of these driving forces is aging. With extended longevity we will see more people who survive various kinds of diseases and maladies and therefore will need the services of the health-care system for a longer period of time. The VA is especially aware of this and must address it in a more efficient and quality assured way in the future. Second driving force is the sophisticated consumer. As the consumer becomes more vocal and more knowledgeable about what he or she wants in the health-care system, pressures will be brought to bear on all health-care delivery systems, including the VA. Technological capability must keep pace. As the technology advances, we must add it and we must figure out a way to pay for it in an arena of decreasing resources. Our health-care capacity will increase; of necessity, we will need to increase programmatic elements and add sophisticated and new manpower to give the services necessary in those programs.

A few years ago when the Veterans Health Services and Research Administration was called the Department of Medicine and Surgery, we addressed some of these issues and driving forces and established certain basic goals. Those goals, in my estimation, are still germane. The first basic goal was to insure that quality medical care is provided on a timely basis, within law and regulation, to eligible veterans now and in the future. The next goal was to maintain a comprehensive system of health care and in doing that we needed to do several subsets of that goal. We had to achieve an appropriate mix of medical services: we had to do high quality education; we had to conduct high quality research with focuses on veteran needs; we had to utilize new technology for better patient care; we had to participate in VA/DOD contingency planning; we had to streamline credentialing processes for professional staff; and we had to evaluate the quality, responsiveness and efficiency of the health-care programs. The next major goal we had to address was to effectively plan and manage the resources. And last, the huge major goal was to meet the needs of veterans with special requirements. That reflects the long and historical success story of the Veterans' Administration. We had to do all of this even in the face of a straight line budget since 1977 and we had to do it more efficiently and we had to do it within an arena of stringent maintenance of quality standards.

Sometime back, during my presidency of the National Association of VA Chiefs of Staff, it became readily apparent to a number of us that the task was complicated and enormous, if not impossible. Being ever mindful of our responsibilities, I appointed a committee chaired by Dr. Ralph Goldsmith to begin to study the future of health-care delivery by the Veterans Health Services and Research Administration of the Department of Veteran Affairs. It was at this time that we first were made aware of Secretary Derwinski's Commission to explore how VA could or should consolidate its services in order to deliver health care to entitled veterans more efficiently. We have continued with that committee and, in fact, here recently we have acquired some seed money in order for us to address philanthropic organizations to acquire more extensive funds to develop a bottom-up "Consensus Development Conference" on the subject of health-care delivery in VA. We are continuing with that effort and hopefully, plan to develop a credible data base that can be used by Secretary Derwinski's Commission. Some of us, including myself, are greatly interested and very supportive of that Commission and are looking forward to its findings, whether it is statutorily mandated or voluntarily implemented by the Secretary. Whatever the path that is finally taken by the participants, there are certain cogent features of policy changes that we feel must be addressed. If the budgets are to be continually straightlined and if the eligibility is to stay at its present level or even expand, then obviously we must change the mission of some of our individual VA facilities. The question arises in our mind as to whether we should change the mission of VA nationally and whether VA has a place in national health-care policy and whether VA has a broader and fuller opportunity to take part in the national health-care scene. A recent Delphi study of the top management of the VA, when asked about issues facing VA health care in the 1990's, gave some interesting results. The following is a final prioritized listing of issues in order of rank.

1. Changing mission of VA nationally and at individual VA facilities.
2. Securing adequate resources as a system.
3. Creating methods for dealing with increased workload with decreased resources.

4. Quality and efficiency of care: Assessment and Evaluation.
5. Rational resource allocation scheme.
6. Recruitment and retention of health-care providers.
7. VA's place in the national health-care policy.

We have before us today two pieces of legislation, S. 1332 and S. 1398. I find the language and flow of S. 1332 somewhat cumbersome while the flow and understanding of the language of S. 1398 is very clear. It seems to me that Secretary Derwinski is going to proceed along with this Commission whether he has legislation or not. The language of S. 1332 seems to be very restrictive of the Secretary, probably more so than needed. The language of S. 1398 has the same requisite reporting responsibilities and the same controlling language but seems to give the Secretary more flexibility. If legislation is truly needed, I would favor S. 1398.

Although it has been some time since an indepth study of VA health-care system has been done, an abortive attempt was undertaken in 1972. I happen to have been a part of that effort and sifted back through my old notes and found some of the tenets of that study. They were the following: (1) we should uphold the longstanding commitment of VA to medical education, both undergraduate and postgraduate; (2) we should develop a stronger relationship with national health organizations and other branches of Government that are involved in health care; (3) we should support larger and broader budgets earmarking such funds for research training and new starts; (4) we should have crisper mission statements for each institution deftly tied to the budget and the strategic planning process; (5) career development of the top management level is essential with some effort at systematized cross-over training; (6) a realignment of whatever organizational infrastructure is necessary to better fit the realities of the marketplace; and last, the redefinition of VA teaching hospital as to structure, function, funding, staffing and programming.

VA's medical care program faces a challenging future with many unanswered questions. The Congress is committed to the Department and its mission and has been steadfast in that commitment. This commitment will be subject to more testing in the future as the Department seeks to shift resources, convert hospital beds to long-term care beds, and prepare in other ways for aging veterans and other imperatives placed against our health-care delivery system. It is unlikely that we will get large influxes of funds in the future. The VA's relationship with private medical care sector could have an influence on the Department's future. For all of these reasons, we can think of nothing more important at this point in time in the history of the organization, than to consider its future goals, missions, organization and function.

Thank you very much.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO THE DEPARTMENT OF VETERANS AFFAIRS AND THE RESPONSES

Question 1. Beginning on page 13 of VA's testimony, there is a discussion of site visits by the Commission being contemplated prior to any recommendation of a major change.

Question 1A. For those site visits, do you anticipate that the entire Commission and key staff will make each visit or that a select sub-group will do so?

Answer. Prior to the Commission's proposing any major change to a facility, the facility will be visited by at least two Commissioners who will be accompanied by a team of staff personnel made up of Commission staff employees or clinical personnel detailed from other field facilities.

Question 1B. How long do you project an average site visit will last?

Answer. We expect some variation from site to site, but each visit should last about two days on average. One day would be to visit and review the facility, talk with staff, meet with patients, and confer with concerned affiliated non-VA hospital CEOs; and the second day would be used for a public meeting or discussion about the facility. Elected officials, local staff of concerned members of Congress, CEOs of related health or medical facilities, veterans service organization representatives and other interested parties would be asked to meet with the Commissioners and staff to present their ideas.

Question 1C. What would be the average cost of such a site visit?

Answer. At this juncture, we expect the average cost to be approximately $5400 per facility visit, but this is subject to considerable variation based on the purpose and duration of the visit, the number of people traveling at government expense, the cost of any meeting facilities, etc.

Question 2. If the Commission were to find that, based on patient needs, a mission change for a given facility from tertiary care to long-term care was in order but that such a change would cause the termination of a major medical school affiliation at the VA facility, what would your guidance be to the Commission?

Answer. The Commission will consider all aspects of a VA medical center's mission, including affiliation arrangements. The Commission is targeted for planning for 2010 and beyond. The Commission might find the need *to change* an affiliation—for example, to expand its capacity to educate geriatricians; or to develop affiliation for ambulatory/primary and extended care. But any changes planned will not be immediate. With strategic outlines it is assumed there will be sufficient time to plan for any major changes. As I have said, facilities will not be "jerked around." Furthermore, one reason for site visits is to begin the dialogue concerning any major changes and to ascertain the "environmental impact." This environmental impact will be taken into account in final strategic plans. Final strategic plans will be developed by the Chief Medical Director in coordination with affiliates, once the Commission's recommendations are approved for implementation.

Question 3. On page 11 of your statement, you note that "veterans service organizations have been asked to suggest persons they believe would be qualified commission members." At the time of the House Committee's hearing on March 14 on this subject, none of the service organization witnesses was aware of a direct request to his organization. Have such requests now been made?

Answer. Yes. The Executive Directors and a President of eight veterans service organizations were called and also sent follow-up notes. There has also been additional telephone communication to answer questions.

Question 4. The American Legion in its testimony for this hearing recommends that "a summary of all Commission proceedings, as well as all records, documents, and other materials developed by the Commission be made available to veterans service organizations." Will this material be made available to the veterans organizations and to the Committees on Veterans' Affairs?

Answer. See our answer to question 5B.

Question 5A. The National Federation of Federal Employees' testimony recommends that the Commission's backup studies, papers, and recommendations be subject to the Freedom of Information Act. As government documents, these materials would be available to the public, wouldn't they?

Answer. See response to question 5B.

Question 5B. In what time frame will they be available?

Answer. As we have testified in connection with our plans for the Commission, we intend to provide briefings and reports to our oversight committees, VSO's, and others on the progress of the Commission. Clearly, we wish to maintain as open a process as possible. As you suggest, the working papers developed by or for the Commission would be government documents, subject to the Freedom of Information Act (FOIA). As you will appreciate, the Commission may work with records which, as a matter of law, may simply not be disclosed (in whole or in part), such as quality assurance records. Other predecisional materials may be subject to FOIA exemption.

I believe it would be premature, at this point, for me to establish any position with respect to disclosure or nondisclosure of *all* materials which are within our authority to disclose. I will, for example, provide the Commission's final report to Congress and other interested parties. There may be instances, however, where we will need to invoke a statutory exemption to provide the Commission members the assurance that they can carry out a free, vigorous exchange of views in working papers without risk of disclosure. Let me assure you, though, that we will certainly seek to balance fairly the respective interests and will not lightly withhold materials from the public.

Question 6. On page 12, you note that the Commission will be directed to give consideration to improvements through "sharing and developing innovative health care delivery arrangements with DoD facilities and with the local community." I assume that your guidance would also include consideration of such sharing opportunities and arrangements between various VA facilities as well. Is that correct?

Answer. There is nothing in the Commission's activity which is intended to disrupt current patient transportation and transfer patterns, sharing patterns within VA, or existing regional networks. It could be assumed enhanced sharing efforts will be required within the VA system in order to guarantee that a continuum of care be preserved.

Question 7. How are the functions of the Commission going to differ from those of the Office of Strategic Planning already in place within VHS&RA?

Answer. Through its MEDIPP process, VHS&RA's Office of Strategic Planning considers a long-range plan to cover a 5-year period. The Commission is charged

with a long-range plan along a 20-year time frame. The Office of Strategic Planning is governed by a number of assumptions within the Executive Branch which affect current operations, budget formulation strategy and policy development. The Office of Strategic Planning builds the VHS&RA long-range plan from submissions of its facilities at the grassroots level to the system at large. The Commission will first look at expected demographic changes over the next 20 years, study the system at a macro-level, and then move to more micro-level analysis. Predominantly outsiders, the Commissioners would have no vested interest in one type of facility or type of care over another, but instead would tend to focus on broad program areas; thus, it can be more objective and independent in its evaluation.

Question 8. The Commission has much work to do with a relatively small staff and in less than 18 months. How do you plan to avoid grouping together for analytical purposes facilities which may in fact be very different?

Answer. There is no basis for assuming facilities or programs would be grouped for comparative purposes as a function of this initiative. We recognize significant differences are seen from one facility to another. As the Commission commences its work it will be asked to determine initially two critical matters: criteria by which the Commission wishes to evaluate each VA medical facility; and the Commission's assumptions about the health and medical care environment of the year 2010. Given the criteria, each hospital will be analyzed against each criterion. There is no intention to study hospitals as "all tertiary," "all primary care," or as "RAM groups." Based on the results of these analyses, the Commission Chair will likely then direct the staff to make further analyses until a strategic pattern appears, based on such variables as 2010 demography, patient characteristics, urban-rural patterns, transportation patterns, and patient care delivery requirements.

Question 9. What will be the role, if any, of Medical Center Directors and Chiefs of Staff in the activities of the Commission and its staff?

Answer. In addition to specific facility site visits and meetings described in our answer to question 1(A), there will be Commission meetings in urban centers where VA operates more than one facility, i.e., Chicago, Boston, and northern and southern California. Medical Center Directors and Chiefs of Staff, among others, will be asked to appear as panels at Commission meetings to present their ideas and explain the projected needs of their patients in the year 2010. These executives will play major roles in the specific facility site visits. It is also planned that Chiefs of Staff will be used on intra-VA details either to visit other sites or to work on the Commission staff for short periods of time. Several levels of executive/clinical staff will likely be required from time to time to assist Commission staff in carrying out Commission directives and assignments. We will be relying on suggestions and assistance from field personnel when necessary.

Question 10. Will the Commission's study of the geographical distribution of the veteran population include a study of the distribution of veterans with special medical needs such as blind veterans and spinal cord injured veterans?

Answer. There is no basis to assume the Commission's charter would lead it to exclude certain patients. The initial thrust will be to look at age cohorts by 10-year intervals to determine where the veteran population will be in 20 years. One might question the level of accuracy of determining the geographic distribution of a comparatively small population 20 years from now; nevertheless, the Commission will undoubtedly study certain segments of the veteran population, including those with special needs.

Question 11. I next want to address the issue of funding for the Commission. As I have previously indicated, I was willing to work with you in developing acceptable legislation to establish a statutory commission, but, in view of the opposition in the House and among the service organizations, that route now seems foreclosed. Although I do not oppose your proceeding with the Commission administratively as long as it is truly independent, I cannot support the diversion to the Commission of funds intended to support the furnishing of health care or benefits to veterans.

Question 11A. According to VA staff responses to our informal inquiries, I understand that the total cost of the Commission during FY 1990 and FY 1991 will be a little over $4.3 million—approximately $900,000 in FY 1990 and $3.4 million in FY 1991. We are told that FY 1990 costs will be distributed among three accounts as follows: $573,000 in MAMOE, $190,000 in GOE, and $134,000 in Medical Care, with the funds paid for the salaries of Medical Care employees being reimbursed—that is, restored—to the Medical Care account from MAMOE account. Is this correct?

Answer. This is correct, but please remember the specific dollar amounts are estimates, and as such, may change slightly as we gain experience with this initiative.

Question 11B. We are also told that the FY 1991 costs would be $2 million in MAMOE, $609,000 in GOE, and $818,000 in Medical Care, again, with the Medical Care salaries to be paid back from MAMOE. Is this correct?

Answer. Yes.

Question 11C. According to your FY 1991 budget submission, at the time the budget was submitted in late January the total estimated cost for the Commission apparently was $3.1 million over FY 1990 and FY 1991—$2,636,000 in FY 1990 and $439,000 in FY 1991—with all the FY 1990 funding to be derived from funds originally appropriated for medical care to veterans. Is that correct?

Answer. That is correct.

Question 11D(i). Do I also understand correctly that VA has now concluded that Medical Care account funds cannot be used for the costs of the Commission?

Answer. Based on a VA General Counsel's opinion on that question, we have concluded that we are, in effect, barred from using such funds for this purpose.

Question 11D(ii). What is the reason for the 40-percent increase—from $3.1 million to $4.3 million—in your estimate of the Commission's total cost?

Answer. The $3.1 million figure was an early estimate based on the legislative proposal (S. 1398). You may recall our bill was a near mirror-image of the DoD Base Realignment Commission bill; the VA Realignment and Major Mission Change Commission which S. 1398 would have authorized, envisioned a different type of activity than the administrative Commission I am now establishing. As opposed to the legislatively sanctioned Commission, this one by its design is intended to be an open, inclusive and participatory one. Costs associated with an administrative Commission are considerably different in their nature.

As a result of the revised design of this Commission—and the maturation of the basic idea, including a number of discussions and internal debates about the nature of the effort and its probable internal processes—the budget estimate has been somewhat enlarged. However, a budget of $4.3 million for such an important activity is considered an excellent investment for the future.

Question 11D(iii). After concluding that Medical Care funds cannot be used for the Commission, I understand that the Department has been seeking a transfer of $600,000 in FY 1990 funds from the Medical Care account to MAMOE in order to provide funding for the Commission. Is that correct?

Answer. We believe the best way to accomplish the funding of the Commission is through an appropriations transfer from Medical Care to MAMOE to support the Commission's costs in FY 1990. However, the supplemental approved by the House Appropriations Committee would transfer the funds from the Minor Construction Appropriation. We urge the Senate to modify the House proposal and enact a transfer from Medical Care.

Question 11E(i). Since you were seeking only a $600,000 transfer in FY 1990 and the total FY 1990 costs appear to be $897,000, I take it that you are planning to use, for the Commission, $190,000 in FY 1990 funds appropriated for other purposes to GOE and $107,000 in FY 1990 funds appropriated for other purposes to MAMOE. Is that correct?

Answer. That is basically correct, but we plan to "back-fill" the vacated MAMOE positions once Congress acts on the FY 1990 appropriations transfer request.

Question 11E(ii). So, your plan for FY 1990 is to seek no new funding for the Commission and to fund its operation entirely through the diversion of funds previously appropriated for other purposes. Is this correct?

Answer. We consider this initiative to be an appropriate use of funds; thus, we are taking steps to obtain Congressional approval to identify funds to support the Commission.

Question 11F. What specific functions will be reduced this fiscal year under MAMOE, Medical Care, and GOE in order to provide the $897,000 in funding for the Commission?

Answer. Under the House Appropriations Committee proposal, the Medical Care and MAMOE appropriations will be reimbursed, allowing positions vacated by employees' assignments to the Commission to be filled. For the General Operating Expenses appropriation, no reimbursement is required. Generally, GOE staff offices will be requested to provide support services consistent with their general responsibilities. In most cases, other analysts are assigned the duties of vacated positions; hiring of new employees will be expedited as necessary.

Question 11G(i). Turning to FY 1991 funding, in your budget request, you included only $439,000 for the Commission—and that funding was proposed to be in the medical care account. Are you now going to request that those $439,000 be appropriated to MAMOE, rather than Medical Care, and that the amount be increased by about $3 million over the amount originally requested?

Answer. No.

Question 11G(ii). Are you requesting any additional appropriations, rather than transfers within your own FY 1991 request, for the Commission and, if so, in what amount?

Answer. The resource requirements for 1991 are currently under review within the Department and the Administration.

Question 11G(iii). If not, what FY 1991 funding functions will be reduced from the levels contemplated in your FY 1991 budget Medical Care request in order to provide the $3 million additional for the Commission?

Answer. See answer to question 11G(ii).

Question 11H. Please provide for the record a breakdown of the costs and FTE by fiscal year, appropriation account, and various categories of expenses (such as consultant fees, honoraria, per diem, travel for meetings, and travel site visits) for the Commission members, for staff salaries and travel, for office space, for equipment, and for printing and binding.

Answer. As you must realize, many of the specific amounts of spending could not be anticipated at this early juncture, before even the entire Commission staff is identified, let alone the Commission or its Chair being appointed. I am attaching a gross estimate by major category of our expected expenses this year and next, but please understand these estimates are preliminary and subject to change.

DEPARTMENT OF VETERANS AFFAIRS—COMMISSION ON FUTURE STRUCTURE OF VETERANS HEALTH CARE—BUDGET ESTIMATE 1990 AND 1991

[Prepared: March 30, 1990]

Account category	Account number	Total 1990	Total 1991
Salaries: [1]			
MAMOE	(.001)	$226,353	$689,834
GOE	(.001)	190,138	620,851
Medical care	(.001)	133,844	758,818
Total—Salaries	(.001)	$550,334	$2,069,503
Consulting honoraria	(.001)	$75,000	$200,000
Travel:			
Commission members meeting	(.001)	$39,750	$170,000
Commission members site visits	(.001)	0	194,000
VACO Commission staff travel	(.007)	7,200	139,500
Field staff details to Commission	(.007)	18,520	183,490
Total—Travel		$65,470	$686,990
Leased space (6/1 occupancy)		$55,944	$168,000
Computers and communication,[2] hardware and software		67,734	108,235
Office equipment, lease and services		0	30,888
Contingencies		82,266	163,313
Total—Computers, communications, supplies and contingencies		$205,944	$470,436
Total		$896,748	$3,426,929

[1] Based on projected FY 1991 average salary level plus 20 percent for fringes.
[2] Purchase of hardware, software, installation, and rental costs.

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO DR. A. WENDELL MUSSER AND THE RESPONSES

Question 1. Last week I asked Secretary Derwinski about the real and perceived possibilities that the Commission and its staff might not be independent of VA's agenda since Secretary Derwinski would be choosing the Commission's members and the Executive Director and 29 of the 30 Commission staffers would be VA employees and are already largely selected. Would you comment on whether that is a concern of yours and, if so, how it might be addressed.

Answer. I, too, have had great concern about the staffing of the commission. The Executive Director needs to be capable of independent thought and must be void of

any parochialism. This same concern could probably be voiced about having such a large number of full-time VA employees as staff; however, let me hasten to add that some VA staff is probably essential. In addition, I have felt that having one or two career field represenatives might be in order. Any propensity for parochialism would be diluted by the other members of the commission but these career individuals might bring an opportunity for more realistic addressment of goals and objectives. The fact that I had a personal interest in this type of activity should be obviously ignored.

Question 2. On page two of your written testimony, you state that you have "acquired some seed money in order . . . to address philanthropic organizations to acquire more extensive funds to develop a bottom-up 'Consensus Development Conference' on the subject of health-care delivery in VA." Would you please provide for the record a detailed description of this project and keep the Committee informed as to your progress?

Answer. During my presidency of the National Association of VA Chiefs of Staff (NAVACOS) I appointed a committee of career VA individuals of recognized skills and intelligence to address "The Future of the VA." We obtained a few thousand dollars from a service organization to allow us to write a proposal which could be presented to large philanthropic organizations to acquire a fairly large sum of money necessary to conduct a consensus conference, a mechanism by which we were going to address the issues. We prepared a lettter for distribution to several of those kinds of organizations and I would like to use some excerpts from that letter which would explain our intent and purpose.

> We are requesting your assistance in funding a "bottom-up" Consensus Development Conference on the future of healthcare delivery by the Veterans Health Service and Research Administration (VHS&RA) of the Department of Veterans Affairs. Since Secretary Derwinski is in the process of establishing a Commission, several of us expressed concern that the Commission might not have the time or opportunity to hear from all the potentially affected groups. In order to facilitate a represenative forum, NAVACOS decided to seek broadly based input for preparation of a report to be sumbitted to the Commission, the Secretary, and the Congress. We concluded that such a reoprt would be best served by a Consensus Development Conference. Particularly, it would include representation from VA employees, veterans service organizations, affiliated medical schools and other health related organizations. Because the cost of such a conference would be approximately $250,000, and to avoid a potential conflict of interest, we decided to seek funding from a number of private sources with a major interest in healthcare delivery in the US.
>
> You may well inquire why non-veteran healthcare delivery should be concerned about, or affected by, VA's internal problems. The answer is all too clear that, if healthcare delivery by VA should be limited significantly by the constraints of federal funding, the responsibility for care of disenfranchised, indigent veterans will fall upon an already overburdened, financially troubled healthcare system. In addition to its delivery of care to veterans entitled by reason of service-incurred injuries, the VA represents a safety net for those veterans who become unemployed, homeless, or otherwise unable to pay for healthcare. Loss of this privilege by a large number of veterans would lead to a greatly increased funding burden by other private and public entities, almost certainly at as higher cost than that incurred by VA. It is the opinion of NAVACOS, therefore, that all health-related organizations in this country have a major vested interest in assuring appropriate input to the Secretary's Commission.

It is our hope that the conference would be held in the fall of 1990 and a report made to the Senior Management Conference of VA at the time of the meeting of the American Association of Medical Colleges (AAMC) in early November.

We are pushing ahead with this plan in mind and have sent this letter out to several organizations. I will keep you informed.

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